hygeia

The Health Magazine of t[illegible] Medical Association

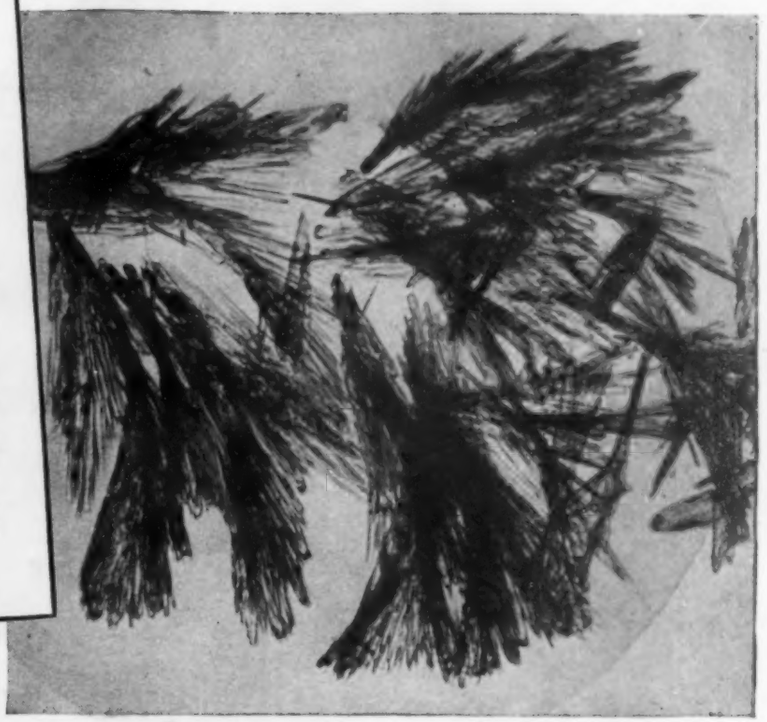
FEBRUARY
1946 25c

"Babies Supervised by Physician

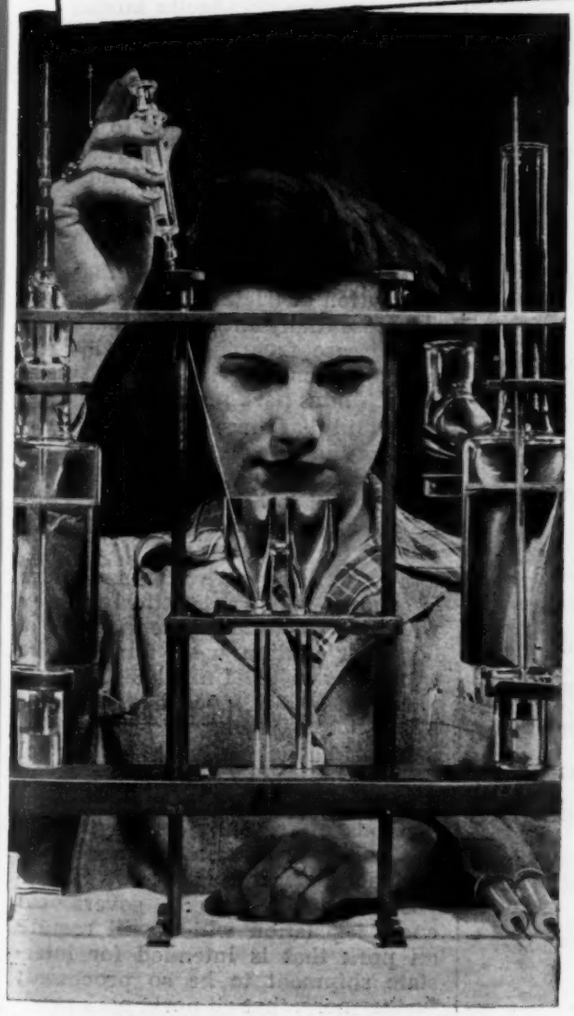
Your health and

VICTORIES IN MEDICAL RESEARCH

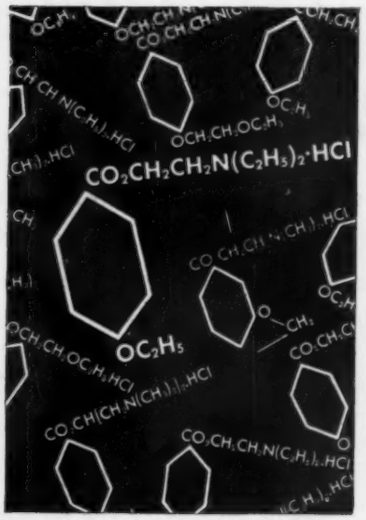
Against every bodily affliction is pitted the relentless, unconquerable mind of man. Physicians in clinics, surgeons in operating rooms, medical scientists in research laboratories like those of Squibb—all are waging a winning struggle against disease. Not all the answers have been found as yet, but the steady forward march of medical science inspires infinite hope. Work being done at the Squibb Laboratories and the Squibb Institute for Medical Research is typical of the efforts of scientists everywhere to make life safer for you.



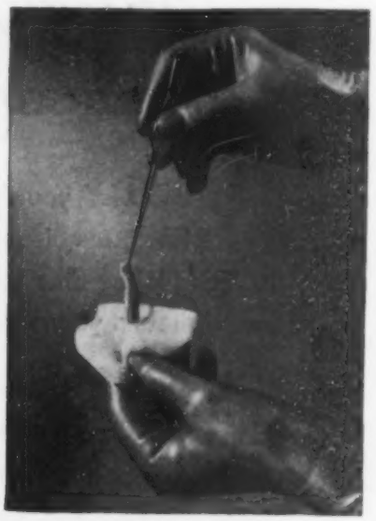
Another germ fighter is aspergillic acid, a member of the newly discovered family of antibiotics, of which penicillin is the most famous. Aspergillic acid is active against many species of bacteria, and offers promise for effective surface therapy. Crystals of aspergillic acid (shown above) look like sprays of spruce needles; they were isolated and chemically analyzed at the Squibb Institute for Medical Research.



New weapon against measles is gamma globulin, a plasma protein produced from blood donations. Its protective action is due to the fact that about 90 per cent of blood donors have had measles and have developed an immunity which can be passed on to others. At the Squibb Laboratories, electrophoretic testing (shown above) insures product purity. Another line of attack against measles is the search for a vaccine—and at the Squibb Institute for Medical Research a step forward has been made by growing the measles virus in chick embryos.



Molecules vs. pain. Seeking a better local anesthetic, Squibb scientists first analyzed the molecule of the best then available. For years they synthesized and tested hundreds of new compounds, rearranging molecules until they created a new product for the relief of pain.



New aid to brain surgery is fibrin foam with thrombin, both derived from blood plasma. Packed in the incision, this sponge-like foam reduces danger of hemorrhage, aids normal blood clotting. Squibb was among the first producers of fibrin foam for military hospitals.

SQUIBB

THE PRICELESS INGREDIENT OF EVERY PRODUCT IS THE HONOR AND INTEGRITY OF ITS MAKER

Smiling reflections

...WHEN YOUR SKIN IS LOVELY

NATURALLY, you are pleased when your mirror reflects a fresh, exquisite complexion. Now when your skin is young is the time to select cosmetics with great care, to help retain your loveliness.

If you are just beginning to use make-up, you will find Marcelle hypo-allergenic Cosmetics a wise selection for complexion care. Marcelle Cosmetics are designed for sensitive skins, and are excellent cosmetics for all types of skins. Known allergens have been omitted or reduced to a minimum. Ask your physician.

* *Acceptable for advertising in publications of the American Medical Association*

Marcelle HYPO-ALLERGENIC COSMETICS

MARCELLE COSMETICS, INC.
1741 N. Western Ave. Chicago 47, Illinois

TRICHINOSIS A PROBLEM

Tiny worms, found in pork, are the cause of trichinosis, a disease that is proving a greater problem in the United States than any other country in the world.

This alarming condition which is menacing the nation's health, was revealed by Dr. S. E. Gould of Eloise, Mich., in a recent article that appeared in *The Journal of the American Medical Association.*

Dr. Gould estimated that each person in the country consumes, on the average, three servings of trichinous pork annually. On the basis that the life span of people in America is 64 years, Dr. Gould estimated that an individual will eat 200 servings of infected pork during his lifetime.

"It is not surprising," Dr. Gould said, "to find at autopsy that at least 16 per cent of the people in America have been infected."

People become infected with the disease by eating raw or undercooked pork which contains cysts enclosing live trichinella larvae.

"Since only about 70 per cent of the pork is produced in plants under federal inspection and since in such plants it is only the processed products that may be expected to be free from living trichinae," Dr. Gould stated, "the larger part of the total American pork supply which reaches the kitchen is open to the danger of carrying live parasites."

Dr. Gould pointed out that the prevention of trichinosis in man consists essentially in the elimination of the disease from hogs that become infected primarily from eating scraps of trichinous pork present in garbage.

He said that three methods for controlling the disease are: microscopic inspection of pork; cooking of all garbage fed to hogs and the processing of all pork prior to its ultimate sale.

How well the control plan operates is shown in a statistical survey which revealed that more than 14,000 hogs per million were found to be trichinous in the United States compared with only seven hogs per million in Copenhagen.

In discussing the third control possibility, Dr. Gould stated, "By processing is meant the treatment by methods of freezing, cooking, smoking, curing or other means according to federal specifications. It is proposed that the federal government enact legislation which will require all pork that is intended for interstate shipment to be so processed; furthermore, that all pork, pork products or meat preparations containing pork be required to bear the following label: 'This product conforms to U. S. specifications for processing of pork.' Likewise it is proposed that all city, county or state health authorities adopt similar regulations governing the preparation of all pork which is intended for local sale."

who's who in Hygeia

Finds Apartment

A varied career, beginning at the age of 17, has led WINFRED VAN ATTA to his present position as manager of the eastern division office of a large chemical corporation and as a successful free-lance writer. There were stops along the way, of course, including one at the Elgin (Ill.) State Hospital, where he worked as an attendant during the early years of the depression. Mr. Van Atta believes that those years provided invaluable experiences. While his articles on different subjects have appeared in 23 national publications, his greatest success in recent months was finding an apartment in New York, after moving from one hotel to another every 7 days since June 28.

Many Interests

Long active in Chicago publicity work, JOSEPHINE BESSEMS, author of the article on orthodontia, has been associated with Marshall Field and Company, Station WMAQ (as author of a daily program), a furniture company, the National Association of Real Estate Boards, Henrotin and Children's Memorial Hospitals, and the Dental Hygiene Institute of Chicago. It was in connection with her work as educational director at the Dental Hygiene Institute that she became interested in the effects upon personality of the repair of serious dental deformities. Her article, entitled "Personalities Remade—by the Dentist," begins on page 122.

Talk About Talk

JAMES SONNETT GREENE, M.D., author of the article on "Hope for the Stutterer," received his medical degree from Cornell University in 1902, and for six years studied at the University of Berlin, Allerheilegen Hospital in Breslau and the University of Jena. Returning to New York, in 1916 he founded the National Hospital for Speech Disorders, and has been medical director of the hospital since that time. The National Hospital for Speech Disorders is the first medical institution in the United States devoted solely to the treatment of voice and speech conditions. In 1944 the hospital treated 3,749 patients from all over the world. Forty-three per cent of them were stutterers. At the present time the hospital is treating many men referred for rehabilitation by the Veterans' Administration. In 1940 Dr. Greene was presented a special gold medal from the American Laryngological, Rhinological and Otological Society for "distinguished pioneer service in the field of speech disorders."

Three Youngsters

This month HYGEIA presents articles by three very young people. ELEANOR S. MORE and CORP. ODOM FANNING are in their early twenties, and ADELE DENMAN is only 19. Miss More is a senior at the University of Wisconsin School of Journalism; Miss Denman, also a journalism major, is a junior at the University of Kentucky, and Corporal Fanning is a Marine Corps correspondent, a graduate in 1942 of Atlanta's Emory University.

Foot Expert

After graduation from Hahnemann Medical College, Philadelphia, in 1907, DUDLEY J. MORTON, M.D., spent two years as an intern and one more year as a graduate student in orthopedic surgery and surgical pathology at Johns Hopkins. He practiced orthopedic surgery in Philadelphia until 1916, when he entered the U. S. Army ambulance service in France. After discharge from service (1918-1919 had been spent as a lieutenant in the U. S. Army Medical Corps), Dr. Morton decided to specialize in clinical disorders of the foot. As research associate of the American Museum of Natural History in New York, he spent five years on research concerning the evolution of the human foot. Following this period, Dr. Morton spent several years on the teaching staffs of Yale University Medical School and then Columbia University's College of Physicians and Surgeons.

Surgeon

A graduate of Columbia University, JOHN J. CREEDON, M.D., attended Cornell Medical College, where he received his degree in June 1940. Following his internship at Bellevue Hospital in New York, Dr. Creedon became assistant resident and then resident surgeon there. He soon was appointed chief resident surgeon at Doctors Hospital, and he is now attending surgeon at Bellevue, Post-Graduate, City, Misericordia and Flushing hospitals, as well as a private practitioner in New York and Flushing.

Helpful Modern Points of View

Suggestions we hope you will find interesting and helpful

Of Special Interest to Mothers for whom after-school hours are a real problem

Modern living conditions and great number of women employed today bring about a new need for guidance of school-age children beyond limits of the usual school day. A possible solution shows itself in trend toward extension of use of school personnel and facilities. Educators explain that this doesn't represent more school, in the traditional sense, but rather planning which takes into account youngsters' need for a well rounded day.

Already certain districts have successfully worked out after-school, teacher-supervised programs. Most include outdoor and indoor activities; games, crafts, music, dramatics. Generally a 4 o'clock snack. A further extension is all-day programs for Saturdays and vacations with balanced lunches and rest; excursions to museums, zoos, etc.

This information—*from Dr. Margaret Hampel, Director, Division of Elementary Education, State Teachers College, Milwaukee, Wisconsin. Also—if you care to peruse Dr. Hampel's contribution to National Education Association book "Towards a New Curriculum," Chap. VI "Extending the School Day and Year."*

It is our desire that the above be helpful to you just as chewing gum helps millions daily. A benefit that might particularly appeal to you as a mother is chewing gum to relieve tension. Good for the youngsters, too. *Wrigley's Spearmint Gum.*
AA-109

TONS OF RELIEF

The lifeline from America to the liberated areas of Europe and China carried 755,600 long tons of relief shipments during November 1945, according to Herbert H. Lehman, Director General of the United Nations Relief and Rehabilitation Administration.

The tonnage, valued at $244,800,000, landed cost, exceeded by nearly a quarter of a million tons the UNRRA shipments for October 1945, the previous all-time high. During November 1945, ships carrying relief supplies sailed from North American ports at the rate of nearly three a day.

"Our heaviest task—if our efforts are to achieve the results for which UNRRA was created—lies in the months ahead of us," Director Lehman explained. "If the destitute peoples of Europe and China are to be helped through the dread winter months, it will be necessary for UNRRA to rush supplies at even greater speed than we have now achieved. To avert outright starvation or death from exposure and disease of hundreds of thousands of war victims, our shipments must far exceed a million tons a month."

Among the countries now receiving UNRRA supplies are Albania, China, Greece, Czechoslovakia, Italy, Poland, Ukrainian S.S.R. and Yugoslavia.

LOOK AT YOUR TODDLER'S FEET!

The X-Ray shows a toddler's foot, twisted and warped in outgrown shoes. Toddlers' feet grow very fast. You *must* get a larger size often.

WEE WALKERS are America's most popular baby shoes because they are soft, flexible, correctly shaped, yet *cost so much less*, you can *afford* a larger size often. No shoe at any price can be healthier for a toddler's normal feet.

See WEE WALKERS...*compare them*...in the Infants' Dept. of the stores listed. Sizes 2 to 8.

COMMENDED PARENTS MAGAZINE CONSUMER SERVICE

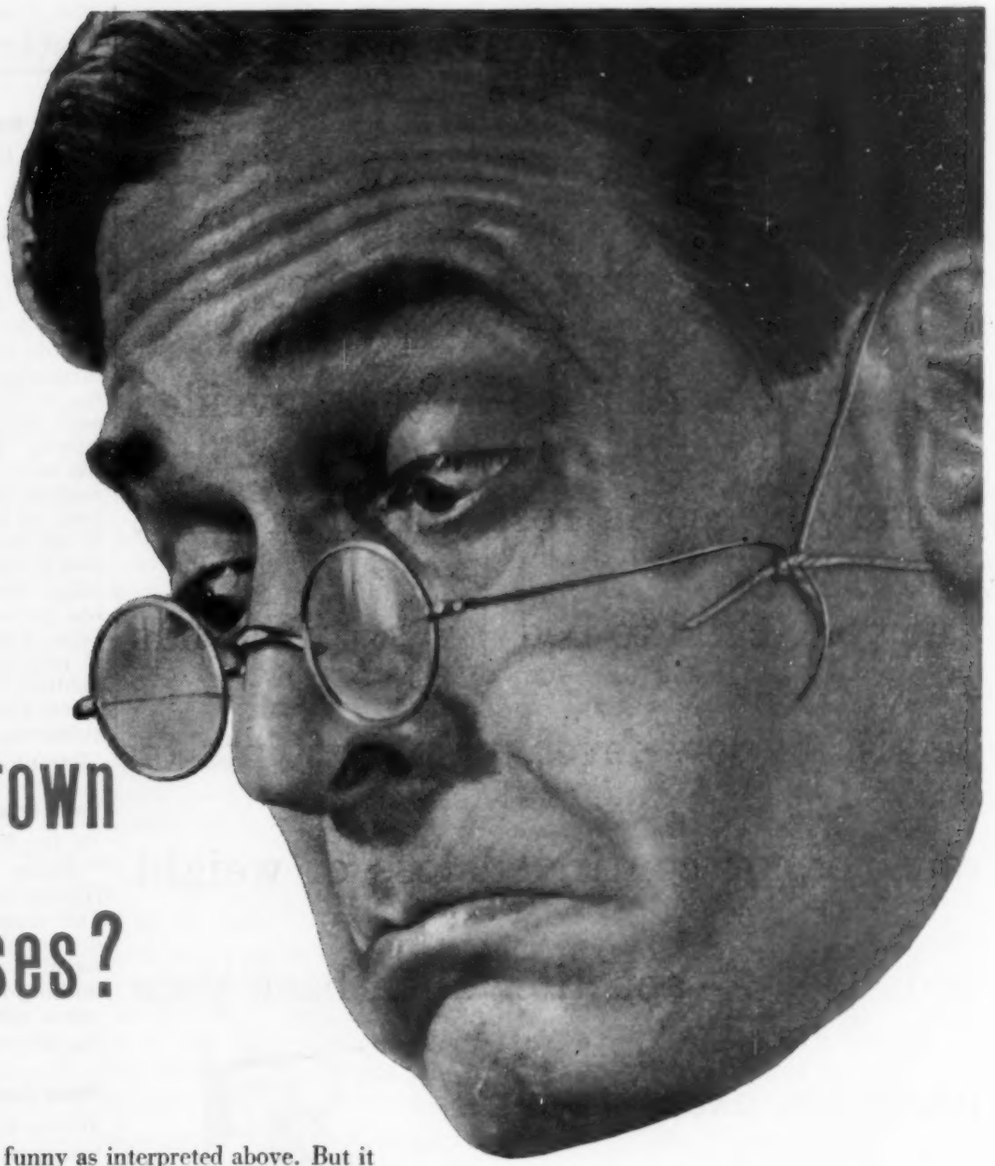
W. T. Grant Co. S. S. Kresge Co. J. J. Newberry Co. H. L. Green Co., Inc. I. Silver & Bros. Scott Stores McCrory Stores Schulte-United Charles Stores Co. Metropolitan Chain Stores, Inc. Kinney Shoe Stores F. & W. Grand Grand Silver Co. McLellan Stores

SMOOTH ONE-PIECE TONGUE

Prevents pressure on nerves, tissues, blood vessels. A feature found in very few other toddler shoes, *even at top prices.*

FREE: WRITE for pamphlet, "Look At Your Baby's Feet." Valuable information on foot care, and scale to measure size needed. Morsn Shoe Co., Dept. H. Carlyle, Ill.

WEE WALKER Shoes FOR Wee WALKERS



HAVE YOUR

eyes outgrown your glasses?

It sounds funny—and it looks funny as interpreted above. But it doesn't feel so funny when your glasses cease to "fit" your eyes . . .

It *hurts* . . . brings eyestrain, headaches, jangled nerves!

That's the only way your eyes can tell you they need new glasses, just as your waistline tells you when you need a larger suit.

You and your eyes change constantly. After a while, your eyes may need a change of glasses—a new prescription to "fit" their changed requirements.

How can you keep up with your ever-changing eyes . . . without waiting for them to cry for help?

It's easy . . . *just have your eyes examined regularly!*

SOFT-LITE LENS COMPANY, INC.
NEW YORK • TORONTO • LONDON

Rheumatic fever can be beaten!

Though it tries to harm the hearts of growing boys and girls, serious damage may be avoided if the disease is recognized in time. Put your child to bed if he has persistent low fever, pain in joints or muscles, or continued loss of weight and appetite. Then have your physician examine him!

If the disease attacks your child . . .

. . . **make sure** the doctor's orders are followed. He should stay under a doctor's care until *all* signs—including laboratory tests — show that no vestige of the attack remains.

Unfortunately, rheumatic fever may *recur*. After convalescence, therefore, be specially careful to guard your child against wet feet and chills.

Try to avoid exposing him to people with "sore throats" and colds. For recurrence may be brought on by these and other mild illnesses, such as grippe and certain respiratory infections.

Sometimes rheumatic *heart disease* may be present although there has been no previous record of a rheumatic *fever* attack.

The only way to discover this condition—and to prevent serious heart damage—is by periodic physical examination.

Rheumatic fever, itself, causes more fatalities among school-age children than any other disease. The way to combat this tragic toll is to maintain youngsters in the best possible condition by proper diet, rest, healthy exercise, and *regular medical supervision.*

To learn more about combating the disease, send for Metropolitan's free booklet, 26-Z, "Rheumatic Fever."

Metropolitan Life Insurance Company
(A MUTUAL COMPANY)

Frederick H. Ecker,
CHAIRMAN OF THE BOARD
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Letters from Readers

Keeps Back Copies

To the Editor:

I am a subscriber to HYGEIA, and I think it is a great magazine which should be read in every home. I am sure the publishers would be interested in having today's issues of HYGEIA live in the generations to come, and I have a suggestion which will do just that. Get an 8½" by 11" three-ring file, perforate holes in the magazines to conform to the rings, and place the magazines inside the covers. The file can hold as many as ten issues. I have made such a book and prepared an index of the contents of each magazine and pasted it in the inside front cover. With this index I can refer to any article in a jiffy. Such a book, if printed, could not be bought for less than ten dollars. I would not sell mine for that. It makes a valuable guide book of medical information. If you think it worthwhile, pass the idea on to your subscribers. GEORGE T. VEEDER

Charenton, La.

Valueless to Her

To the Editor:

Please cancel my subscription to HYGEIA and refund $1.00 as promised. The magazine is valueless to me. I do not need a magazine to tell me when I need a doctor. It contains nothing I do not already know. I am not a neurotic. MRS. M. E. MOON

Los Angeles, Calif.

Plain Facts

To the Editor:

I used to say and I always will,
HYGEIA's a cure for many an ill
For people's ills are oftentimes
Caused from a remedy bought for a dime.
A doctor's book—while it is good,
Is filled with words not understood.
HYGEIA's just some close up talks
Which tell us how we breathe and walk.
It's common sense for all to learn
What will cure and what will burn.
How to know when danger lurks
How to tell a quack from a clerk.
To cultivate your common sense
The reward is great for the small expense.
Get a HYGEIA and read it through,
You may find out what's wrong with you. GLADYS HICKS

Foster Center, R. I.

Thanks

To the Editor:

Many thanks for your articles on diabetes, especially the one in the October issue. This article should remove the feeling that children with diabetes are invalids. I am a child diabetic, and I know that undue preference from teachers is embarrassing.

Reader's Name Withheld

Medical Military Service with Distinction

—An Editorial by MORRIS FISHBEIN

SINCE the outbreak of World War II, more than 225 physicians were reported killed in action and 409 additional physicians died in the military service. Altogether more than 60,000 physicians served in the armed forces, representing well over a third of the active medical profession of the United States. Moreover, every physician who remained at home has been under severe strain to meet the demands placed on him. The record of deaths published each week in *The Journal of the American Medical Association* is an indication of the extent to which this extraordinary strain affected the medical profession.

Up to the first of December 1945 almost 1,500 physicians had been distinguished by recognition with citations or medals or decorations for a variety of distinguished services rendered to their nation in the war. These varied from the establishment of organizations that saved the lives of thousands of men to the making of individual discoveries which achieved world-wide recognition. The Bronze Star was conferred on 297 physicians for exceptional conduct which included bravery equal to that of the most courageous of fighters under the most hazardous of conditions. With peril to their own lives physicians have entered the holds of vessels burning or sinking at sea to care for the wounded and to bring them to safety. Physicians have gone into the midst of exploding shells to administer first aid and blood transfusions to the wounded.

The Silver Star has been given to 100 physicians; the Legion of Merit to 145 physicians; the Soldiers Medal to 46 physicians; the Medal of Honor to 3; the Navy and Marine Corps Medal to 17; and the Navy Cross to 14.

A special distinction is the awarding of the United States of America Typhus Medal. Our control of typhus during this war has been one of the outstanding accomplishments of our military service. An incipient epidemic in Naples that might have cost the lives of tens of thousands was kept under complete control so that only hundreds were affected. Nowhere did typhus threaten seriously the lives of our American troops. Thirty-four physicians received this award.

Among the miscellaneous citations were the Croix de Guerre, the Italian Cross for War Merit and the Cross of the Knight Commander of Italy. The Medal of Distinction was received by a physician and many others received foreign decorations.

Finally, the Distinguished Service Medal, which is the highest of the decorations for exceptional military service has been, up to the first of December, given to 19 physicians. These included:

BRIG. GEN. RAYMOND W. BLISS
BRIG. GEN. PERCY J. CARROLL
REAR ADMIRAL WILLIAM CHAMBERS
CAPT. GEORGE B. DOWLING
MAJOR GENERAL WARREN F. DRAPER
MAJOR GENERAL GEORGE C. DUNHAM
BRIG. GEN. LEON A. FOX
COL. JAMES O. GILLESPIE
BRIG. GEN. MALCOLM C. GROW
MAJOR GENERAL NORMAN T. KIRK
MAJOR GENERAL GEORGE F. LULL
MAJOR GENERAL JAMES C. MAGEE
MAJOR GENERAL SHELLEY U. MARIETTA
BRIG. GEN. JOSEPH I. MARTIN
BRIG. GEN. FRED RANKIN
BRIG. GEN. JOHN A. ROGERS
COMDR. JAMES J. SAPERO
CAPT. EMILE G. SCHUSTER
BRIG. GEN. JAMES S. SIMMONS
MAJOR GENERAL MORRIS C. STAYER

No doubt the list is as yet far from complete. When the record of the war is finally compiled the names of physicians who sacrificed their own lives that others might live, who contributed exceptional ability in the field of scientific discovery, in administration and in leadership, will give added luster to all of those of the medical profession who mitigate, so far as they can, the horrors of war.

Suffer Little Children

By WINFRED LOWELL VAN ATTA

THE prominent neurologist was again confronted with a task, performed several times each week, which repetition could never make routine or impersonal. His face was gentle and kind as he looked up from the clinical reports on his desk into the anxious eyes of a young man who waited nervously for him to speak.

"I asked you to stop in without your wife," he said, "because I wanted to discuss your baby's case with you alone. May I ask what other doctors have told you about your child?"

"They said that she was handicapped and slow—that a sure diagnosis could not be made until she was older. Dr. Greene referred us to you. He said that you would tell us the truth."

"What do you think is wrong with your child?"

"I've known for several months that she is different from other children her age, but—"

"Your little girl is hopelessly deficient, son. There isn't a chance that she will develop mentally. I am sure."

Tears came to the young man's eyes and his knuckles were white as he gripped the arms of his chair. "How can you be sure?" he asked.

"We've made every known test and we've seen hundreds of cases just like this one. The brain power simply isn't there. . . . It's tragic and unfortunate, but you must accept the truth. You and your wife are young. There will be other children. Chances for a recurrence in a second child are less than one in a hundred thousand."

The young man rose and started for the door, but the doctor called him back. "Sit down," he commanded sternly, "and listen to what I tell you! No one can force you to follow my advice, but if you want a happy future for your marriage, you will do exactly as I say. . . ."

The young man listened, feeling inadequate and desperate, confronted by one of the most heart-breaking decisions life has to offer.

I know, because I was that young man.

It was thirty blocks from the hospital to our apartment. I walked slowly, thinking, trying to delay the moment when my wife would look into my eyes and read the truth. Our little girl was a beautiful child, with yellow curls, a sweet smile, showing few of the outward defects found in such children; no baby could have been more adored. Knowledge of her handicap had sharpened our instincts for loving and protecting her, making the doctor's instructions seem cruel and inhuman. Yet, deep in my heart, I knew that his advice was good.

For five years before our marriage I had worked in a large psychopathic hospital, first as an attendant, then as secretary to the clinical director. I had written numerous case histories of imbeciles, kept in the homes of their parents for years, only to be committed to an institution after some antisocial act brought them to the attention of law-enforcing agencies. More important, I knew of the damage done to normal children when forced to grow up with such a child, loving it, fighting for it, but in their hearts feeling shame, refusing to bring friends into their homes to witness their humiliation. I knew also of mothers who had become broken in spirit and health from caring for such children, rejecting the truth until they themselves became abnormal and objects of pity.

The doctor had told me to take the child from its mother by force if necessary. As the father, it was my duty to make the decision. My wife is a college graduate, intelligent and practical, with several years teaching experience, and knew, even better than I, what keeping such a child entailed. We discussed the problem over and over again through our tears, always arriving at the same inevitable conclusion. As intelligent adults, with a responsibility to ourselves, to society and to our unborn children, we had to follow the doctor's advice. A private nursery, with monthly fees ranging from $70 to $150, presented a financial burden far beyond our means. It had to be a state institution.

This article is not being written to solicit sympathy for ourselves, but out of consideration for the countless thousands of parents who have yet to face the same tragedy. It has now been

almost three years since we made our decision. I believe we have gained an objective insight which qualifies us to suggest to others an intelligent approach to the problem. Friends and relatives have a definite obligation to such parents and can make the period of emotional recovery infinitely less painful and distressing.

From the beginning of time, abnormalities of the mind have been viewed with fear and awe by the masses. Less than a hundred years ago, the mentally afflicted were often treated as saints or burned as witches. Superstition still persists in the minds of many people and, out of ignorance, they refuse to accept the mentally deranged or deficient with the same compassion reserved for the physically sick, preferring to look upon such afflictions as visitations of evil or as compensation for the "sins of parents."

This sort of thinking is utter rot and the most vicious form of cruelty. The same conditions which can produce a club-foot, a hair-lip or withered hand, can produce a withered brain. A benevolent nature often solves the problem through miscarriage, but thousands of such children are born each year, deformed mentally or physically. These children are called developmentals by doctors. If the child is mentally deficient, a good pediatrician can usually determine the degree of incapacitation by the age of two. If the child is an imbecile or idiot, he will invariably recommend institutional care, either private or state.

The most important thing for the parent to understand when he learns the truth is that there is nothing shameful or disgraceful about his tragedy. It has happened to presidents and vice presidents of our country, to doctors, to professors, to people in every walk and profession of life, occurring just as frequently, or more often, to parents of superior intelligence as to parents of low mentality. There may or may not be a family history of such afflictions. Only rarely does it happen more than once to one father and mother.

The very thought of placing your own flesh and blood in an institution will be repulsive to you when you first consider it. If, like us, you have not learned the truth until the child is 2, you will love it more passionately than you would a normal child, which is taken for granted. Fortunately, such institutions are greatly different now than in the old days, when cruelty and barbaric methods were considered practical for handling mental cases. Some states have better facilities than others, but most state hospitals are exactly what the name implies—hospitals, operated by a trained medical and nursing staff.

Our state is known throughout the country for its efficient Department of Public Welfare. Having worked in one of its large hospitals, I was familiar with the type of medical men operating them, and had every confidence in their humanity, yet the thought of committing our baby to the care of strangers was almost more than we could bear.

Deep in the heart of every such parent hope remains. Suppose the doctor was wrong. What if the child should suddenly begin to develop two or three years later?

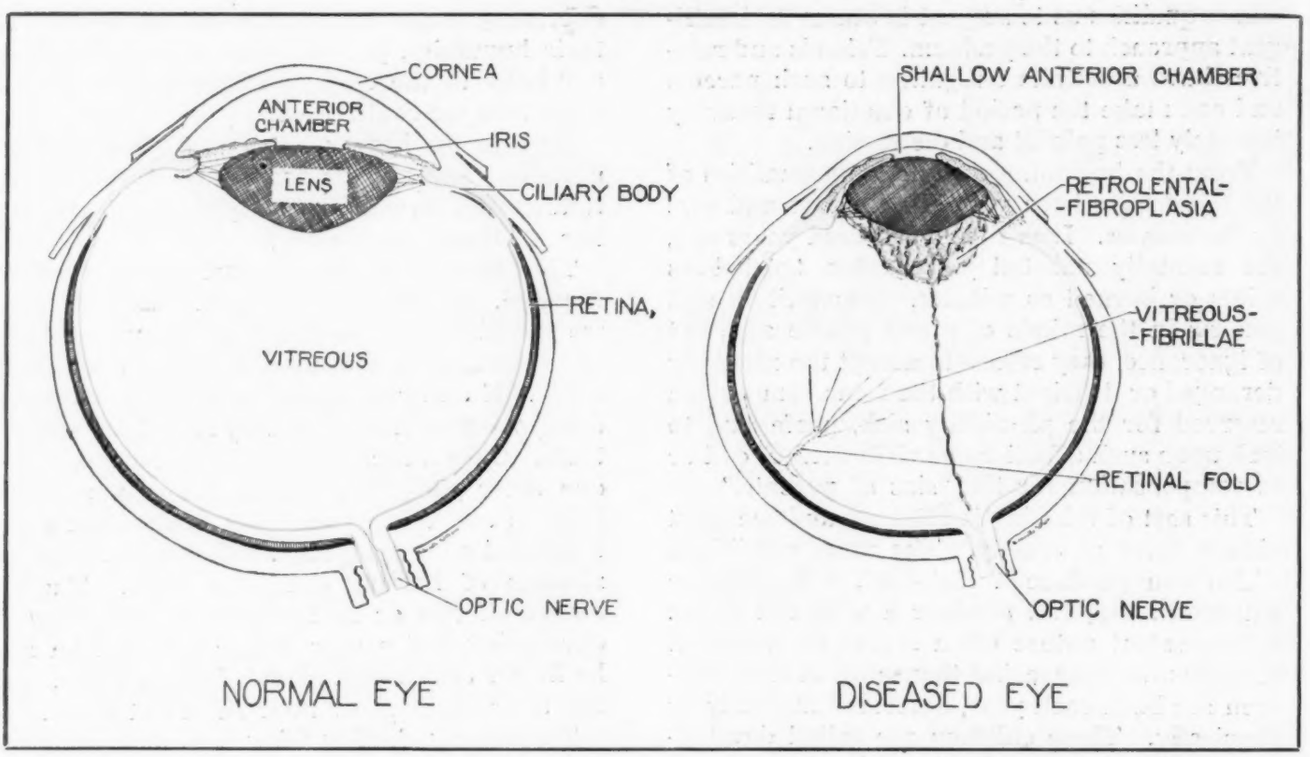
This sort of thinking must be avoided or repelled. For the parents' own peace of mind, we would suggest that at least three reputable pediatricians be consulted before a decision is made. If all make the same recommendations, then you can be sure that they are telling you the truth. Once a decision has been reached, let no one deter you from taking immediate action. Friends and relatives are apt to shed crocodile tears and offer sympathy. They will make the mistake of holding out false hope. They've known of this or that child who was slow in developing, but a new doctor treated him and he began to develop. Don't believe them. It's not their problem or their future at stake.

The one comforting thing for every parent to remember when facing this problem is that the emotion is all on your part. The child is emotionally dead and it matters little to it who brings its food and tends to its bodily needs.

This you will find hard to believe . . . at first. Your child is different. You know that it responds to you. We felt the same way. Our baby was utterly indifferent to us when we visited her a week after she had been at the hospital. Strangely, a great apprehension will be lifted from your mind when you realize that the child is just as contented with a stranger as with its own parents.

Therefore, the real danger is in the adjustment of the parents themselves. They must realize that they have, in a sense, committed a crime against nature. It is the instinct of every animal to protect its young. If the offspring is handicapped, then those instincts will be sharpened and more deeply felt. It is imperative that such parents rationalize their actions and find justification for them. Man is more than a mere animal. He has the capacity to think and plan ahead, weighing one line of action against another and deciding which offers most in the way of mental tranquillity. Whatever civilization we have today has been attained by such reasoning; by sublimating animal instincts and responding to cold logic.

The problem is hard enough with any child, but if, as in our case, it happens with the first and only child, then the suffering is infinitely greater. There will be at least a year of mental anguish unlike anything *(Continued on page 138)*



Diseased eye casts its dark spell in a fibrous vascular curtain of retrolental fibroplasia on back of the lens. In the left eye note the shallow anterior area, the vitreous fibrillae and retinal fold on the diseased member which characterizes this malady in children of premature birth

The Eyes have it

By WILLIAM F. HOMER Jr.

MANY "miracle" drugs and "miracle" cures have won their medical B as well as a measure of public esteem. But, even an age of the miraculous holds a challenge to science in a rampant new disease still veiled in mystery. This eye scourge called retrolental fibroplasia has less than five years' detection and study. Its cause, prevention and cure are not known. Its treatment still must be discovered.

Yet "challenge to science" is a cold approach to the miseries and heartache of this blinding affliction. For this dread new malady strikes at infants. It draws a foggy, impenetrable curtain over the vision of one out of every eight premature babies.

The Foster twins at 4 months were lovely, every one agreed, although Margaret's irises were turning brown and Mary's, somewhat smaller, remained baby blue. But the identical, flaxen-haired sisters were beautiful, no mistake, and no more than the Fosters deserved.

Their birth had been two months premature, and it was touch and go for a while whether they would live. It was almost too much to hope that both would come home to the bassinets in the guest room, the pink one that David had used, and the blue one, borrowed from the Nortons.

Life began for the sisters in two incubators, side by side, and life from the start could not be dull if the twins were going to survive. Special nurses, special food, consulting specialists and special operators for the incubators, day and night! Herb and Martha Foster hadn't figured on these when they decided that David should not grow up alone. They hadn't even figured on twins. Herb worked hard at his accountant's job, but wartime prices stretched the budget and the incubator extras just ran through their savings.

"Forget it!" Herb said to an apprehensive Martha the day the twins "graduated" from hos-

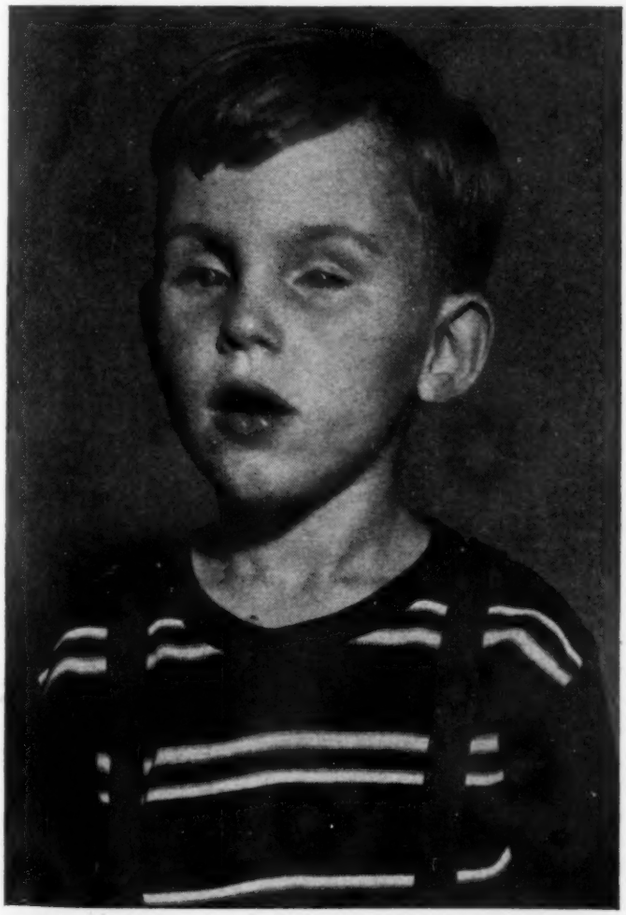
pital to home. "It isn't every guy can send one girl to a hospital and bring back three."

But those incubator weeks for Margaret and Mary had told on Martha, too. She was pale, fidgety from the trials of premature birth, and the daily, even hourly vigil over the flow of life. How could those delicate, partly formed lungs and digestive systems perform their life-giving tasks two months too soon? They were almost on their own, from the first, with no ties to mother's apron strings.

But the twins had come home—been home now two months, all ready if not to sit up, at least to take notice. They'd pull through the pediatrician had said.

But Martha still looked worried, almost frightened, Herb noticed. Minutes at a time, she'd just look at the twins, not saying a word. She'd hold up a rattle to Margaret who would beam and wave a chubby fist. Mary would turn her head at the rattle's rasp, but make no sign as the toy moved over to her bassinet. Maybe Mary would be the placid one.

Yes, Mary would be the placid one, not from temperament, not from choice, but simply from a tragedy after birth. Mary could not see! Darkness entered her life on the wings of the two long words, retrolental fibroplasia.



Lacking guidance a blind child sits and waits. He must be taught everything—to escape passivity, to play—perhaps to chew. He simply must be reached

These dire new terms of infancy have developed from a five-year study by eye doctors and technicians at Massachusetts Eye & Ear Infirmary, Boston Lying-in Hospital and Harvard Medical School. This eye disease is identified with premature children two to six months after birth. It is not unknown but it is almost a phenomenon in children of full-term nativity. In these rare cases, the disease usually dims only one eye.

As better care of premature babies increases the number that live, the seeds of this mysterious malady will find a wider field of fertile soil. Of the approximate 3,600 "seven months" babies born in this country each year, about 432, or 12 per cent, or one out of every eight will not have the blessing of sight. This is the toll of retrolental fibroplasia.

Ophthalmologists, or experts in eye disease, know what the affliction is and where it strikes. They do not know why, nor can they offer a prevention or cure. But the forces of medical skill, laboratory, school, clinic and specialized social service strive jointly to provide relief. They are marshalling their resources for new ways to assure that premature blind babies do not live in vain and that their days of darkness are not hours without joy. They are striving to build morale, and to banish discouragement and the unwarranted sense of guilt that besets the parents of the stricken children.

Retrolental fibroplasia is a growth of abnormal fibrous tissue behind the eye's crystalline lens. It impairs vision by preventing light rays from reaching the retina. In 95 per cent of the cases, both eyes are affected.

When the eye becomes an entity in the mother's womb, its growth is rapid. A web of blood vessels spreads nourishment through the tiny eyeball. As the growth of the crystalline lens proceeds, the need for elaborate blood vessel feeding diminishes. Substitution of a new nutriment, a clear, colorless fluid, aqueous humor, takes place. The original blood vessel net falls into disuse and eventually disappears two weeks before normal birth.

But the unbalanced organic engine of extremely premature infants often develops trouble in the eyes. An opaque, white tissue, fibrous in nature, grows on the back of the lens within the meshes of the blood vessels before they would normally disintegrate. As this spreads, the blood vessel or vascular system which had apparently closed reopens to carry blood again.

Fibrillae may fasten onto the retina of the eye. Like the Lilliputians tightening the cords on Gulliver, they will pull and haul until folds or separation or other injuries to the retina result.

This damage didn't happen to Mary's eyes. But they stayed baby blue as the irises were strangled. The eyes failed to grow, with no supply of their normal *(Continued on page 155)*

THOSE who deal daily with our returnees are continually impressed by their personal achievements in the war, and their remarkable psychologic and physical endurance.

How have they changed from what they were like when they first left home? What is their reaction to the home scene from the point of view of a man still in uniform? How is the home environment to adjust itself to the needs of the returned servicemen?

The returnees are glad to be back, glad to see the job of winning the war finally accomplished; they are more mature. They see their families and home communities and themselves against a wider background of war experiences.

Home-coming means a reversal of adjustment. The man comes from an army environment in which individualism is suppressed. He has been separated from his family for years, and has gone through combat and hardships. He has had warm friendships; often these friendships were stronger than any he experienced in civilian life. At the same time he has had to live without privacy, in large groups who were not of his choosing. He has had to learn teamwork, and to depend on it. And, as part of an authoritarian regime, his attitude toward individual initiative has undergone a change. He has used his initiative, but only under certain rules, and with supervision. His social attitudes, too, have altered somewhat. Combat was a highly personal experience for him—he fought largely for his own leaders and his own buddies—but his participation in world events has made him more aware of the interaction between the broad world scene and the individual.

He returns to his individual family, town, or neighborhood where people greet him by his first name, and he is again included in groups of prewar friends. Many returnees have the problem of earning a living—and adjusting to work and employer relationships—others may be planning to return to school. Fiancees, wives, and, in many cases, children are waiting for the returnee to resume the role he left years ago.

What aftermath from his war experience makes the transition period difficult? Let us outline his problem, and explore the factors that will help him solve it. Underlying the main problems that bother the veteran is this: He has to master an aftermath of anxiety related to his war experiences, and this overlaps with his uncertainty about future problems of making a living and adjusting to the civilian scene. He has to regain confidence in himself.

During his years overseas, and particularly in combat, fear had to be "damped down." Every soldier normally felt a certain amount of fear, but controlled it. In addition there was the necessity for constant alertness. Living conditions were difficult—food was monotonous, sleep often interrupted, and there was frequent exposure to harsh climatic conditions. All of this normally leaves the human organism in a state of fatigue, with more or less tension and restlessness. There is temporarily some depletion of ego capacity after war experience. Diminished ego capacity might be defined as the let-down feeling any normal person has after a period of tremendous effort. After a hard, frustrating day in your office, you may come home very tired, for example, but this exhaustion is only a small fraction of what the soldier feels, after years of hardships.

Personality

He wants to gratify years of wanting things—good food, lots of relaxation, avoidance of effort for a time. The returnee has an urge to repay a debt to himself for years of frustration. One man for example had a hard time remembering to pay the check in civilian restaurants—but underlying his forgetfulness was the need to receive things—to be taken care of, to have dependent feelings gratified.

Before the returnees feel completely ready to assume family responsibilities, they require a few weeks of rest, and then a period of gradual

By MILTON L. MILLER

of the Returned Veteran

assumption of such burdens. Yet, responsibilities may have piled up, and the end of the war came suddenly, bringing immediate problems of competing to earn a living. Problems await the returnees as soon as they get home. The family often has a tendency to confront the soldier with all sorts of decisions to make for them, and they confide their health and financial problems to him as soon as he is back. He is anxious to help them. For the reason that he feels depleted himself, he may be the more aware of the necessity for his family to make plans and to solve certain problems. He then has a tendency to worry excessively, or to feel increased tension at home.

For example, one returnee had hoped that on his furlough home, all he would do would be to drive around in a car, and go to the beach, and lie in the sun—and forget everything else. He wanted to have a good time with his friends. Other returnees seemed to be enjoying themselves, but when he got home he felt restless and could not relax. He had had three years of jungle fighting during which time he suffered from malaria—and many of his closest buddies had been killed. When he came home he immediately had to think about supporting his parents and younger brothers and sisters. He had a fiancee who had been waiting for him and wanted to marry him right away, but he did not feel ready for marriage. When he took his fiancee to the beach they quarreled all the time, about this. He was not ready for the responsibilities of mar- *(Continued on page 144)*

RIGHT

When shoes are fitted properly, as here, the problem of aching feet will be less troublesome. Bones and toes are not cramped, ball of foot rests on widest part of sole, and the heel is held firmly

WRONG

Wrongly fitted shoes force toes and bones to conform to shoe-shape rather than to natural lines. Here toes cannot lie straight, ball of foot is not properly placed, and the heel can slip

ACHING

RECENTLY the remark was made that flat tires and flat feet were becoming a sign of the times. During and since the war the strict rationing of gasoline and tires, scarcity of domestic help, the expansion of industrial activities and the reduction and crowding of transportation facilities, have combined to increase the demands upon our feet. Although we have little reason to believe that actual foot disorder has increased, aching and painful feet are more widely experienced because many of us have been forced to use our feet to the limit of their endurance.

Regardless of whether feet are structurally perfect or imperfect, the chief cause for aching feet is *overwork*. In normal feet the symptoms clear up quickly with a brief rest and the discomfort is diffused throughout the feet; in feet that are not normal, the symptoms appear more quickly each day and take longer to subside, steadily becoming more constant and more acutely localized in certain spots. The strains a normal foot can take are too much for a weaker foot.

The first and most important phase of treatment of all aching feet—the good ones as well as those which are not so good—is *rest*. Hard-worked feet require a corresponding generosity in rest. The best sort of rest for the feet is a relaxed horizontal position of the legs and feet. That position promotes the freest flow of blood through them.

Another source of foot pain definitely within the power of the individual to control is *shoes*. He is the only one who knows how a pair of shoes feels on his feet, and his best guide is comfort. Painful corns, bunions, ingrown toenails and distorted toes are the most typical signs of faulty shoe. If foot discomfort is chiefly confined to these places, there is a good chance that the trouble lies in the use of poorly selected or poorly fitted shoes. Apparently many people don't realize that feet differ in shape and that the greatest variation occurs in the front part of the feet. An angular foot with a long first toe may wear a pointed-toe shoe without discomfort, but any attempt to squeeze feet that appear square across the front into a similar

pair of shoes, is to invite trouble. The correct shape of a shoe is just as important as its correct size. A good guide to proper shoe shape is an outline tracing of the stocking-covered foot. The best kind of shoe for daily working hours is an easy fitting sport model shoe, and, in the case of women, with the lowest heel that can be worn without discomfort.

When feet continue to be painful and achey in spite of attention to rest and a check-up on the shoes, some fault within the feet should be suspected. Two easily recognized definite signs of internal disorder are the formation of calluses on the ball of the foot and the "weak ankle" posture of the foot which is technically spoken of as "pronation."

It is not necessary to be concerned about the height of the arches. Many of the most painful feet have well developed arches, while many feet with practically no arch have never experienced any foot trouble. A high or a low arch can be compared with a high or a low table. From the viewpoint of structural strength, it is not the height of the table that is important, but the stability of the framework and the legs that support its weight; similarly, in the foot the way the bony framework of the foot supports the weight of the body is important and the height of the arch is not. There is no need to feel disturbed when someone tells you that you have fallen arches. Arches do not fall so easily! Certain ligaments and joints of the foot can become strained and painful, but it is only under extraordinary circumstances that any recognizable change in the shape of the arch occurs. In

FEET

By
DUDLEY J. MORTON

fact, it is no more accurate to use the term "fallen arches," as we commonly do, than it is true to say a person is going blind when he complains of a few symptoms of eye strain.

Whenever a person experiences some symptoms of eye strain, or a tooth begins to ache, there is little hesitation about going to the eye doctor or dentist for proper examination and treatment. Few people realize that human feet are highly developed organs—that through countless centuries of evolutionary change our feet have acquired a high degree of specialization for the one particular purpose of direct interaction with the force of gravity. Their commonplace function of carrying the weight of the body seems completely lacking in anything mysterious or extraordinary, but human feet contain a mechanism of special design. By means of it, the 5 year old child, playfully running, tosses his 50 pounds of weight from one foot to the other as easily as an adult might juggle a baseball with his hands. The feet are as specialized in function as the eyes and ears and they must last a lifetime, occupying an essential role in our physical, social and economic welfare. Unfortunately, there is no part of the body which offers a greater temptation for self treatment, even though treatment of internal disorders of the feet calls for more than untrained effort. A doctor's help should be sought when difficulties arise. X-ray examination is the most reliable means of revealing the defects in foot structure that are responsible for disorders, as well as the degree to which the mechanism of the foot has been affected by them. Constitutional and other forms of local disorder other than mechanical, may be the cause of symptoms.

When feet have been persistently painful over a long period of time, don't expect that the mere application of some foot device will immediately clear away all symptoms and permit unlimited use of the feet. In such cases, the long continued pain invariably means a state of chronic irritability of the nerves that can be overcome only by patient care. Restriction of activities and serious attention to rest are of utmost importance until symptoms are brought under control. Return to full activities should be undertaken gradually.

Constant use of high heels is the reason why foot trouble in women is about ten times as frequent as in men. The popularity of flat heel shoes among girls and young women today will go far toward preventing future foot trouble. Contrary to a widely held idea, alternate use of high and low heels is not harmful to the feet; use of low heels throughout the daily working hours will counteract any unfavorable influence of high heels used during social activities. However, women whose feet have been affected by long use of high heels are in a different category. If they attempt to adopt low heels, the change should be made gradually.

SHARP POINTERS ON FEET

Aches and pain in the feet are caused by nerve irritation, which in turn is caused by overwork or overstrain. Don't give more exercises to overworked and achey feet—give them rest and *more* rest if necessary. A comfortable sport type of shoe is the best kind for strenuous daily activities. Be as careful in selecting the shape of the shoe as in selecting its size. Have confidence in your feet to tell you if the shoes are comfortable or not. But remember that feet with irritated nerves cannot be expected to be made comfortable by means of the shoe alone. Such discomfort is not the shoe's fault—it merely informs you of the irritated state of the nerves and emphasizes the need for general care. When internal disorder of the feet is suspected, don't avoid seeking a doctor's help. You will probably come to it eventually, with a more chronic condition that will be slower in responding to treatment.

What High School Girls Think

ABOUT HEALTH (*or do they?*)

By AIMEE ZILLMER

I want to say to begin with, that I'm fond of the adolescent girl and, though not a cowardly person, I hesitate to comment on how I think the high school girl rates health.

For, when it comes to health, I think she is a bit of a fraud. If a style, custom or manner is initiated by a Powers or Conover model, or a movie star, it's adopted by "the gang." By "the gang" I do not mean a vicious or criminal group, but rather the teen-age set that adventure together and who, in spite of home influence, establish their own fashions. Fashions that probably do not harm their health—that may even help it—but that aren't adopted because they are healthful.

It's beauty first with the adolescent girl of today. I think that any similarity between her appearance and her search for health, is purely accidental.

She combs her long bob until it is a glistening crown of glory. She combs it not as a hygienic measure, but because she loves the way it looks. She values its appearance to the extent she may even renege in taking a shower or bath or entering the pool.

The long nail fad of the "teen tribe" results in nicely cared for, healthy, unbitten nails. She tans, yes, burns every displayable inch of her body. She "bakes" for style even though a dark tan may defeat health purposes.

Her moccasins, saddle shoes and hueraches look as sensible as carpet slippers, and provide as much support. Her cable socks smother her ankles. Her feet bear the brunt of high heels, low heels, heel-less and toe-less foot coverings. Ah, logic—where can one find any relation between health and fashion in this domain of adolescence?

Her head is covered, when it is covered, to hold her hair in place—regardless of whether it is 100 degrees in the shade or 30 degrees below zero. If her hair is freshly done, or still moist and pinioned down with metal gaggets or bobby pins, she may wear a babushka or turban. Many a high school girl has attended a day's classes with her headgear covering wet hair.

Her posture is fair. Tummy and "derriere" mustn't bulge. She must have curves, but not in these places. The high school girl doesn't talk weight quite as much as formerly, but physical education instructors tell me that she almost never fails to step on the scales. This gay deceiver watches her diet because of her build and complexion. As a matter of fact, the omitted breakfast and the resultant dull headache in the morning is still true. To her, weight and complexion are not a sign of inner health; they are window-dressing; they are display! Pimples, bad complexion—are just too, too awful! The popular soap advertisements teaching her how to massage her face are followed conscientiously.

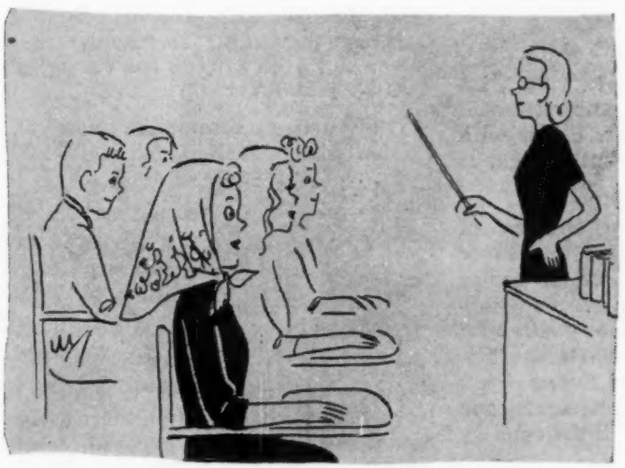
Why can't we make scientific health facts as alluring as beauty advertisements? The adolescent girl's healthy appearance comes mostly from styles. This isn't criticism, of course, if the style coincides with good health. This is also true of other age groups that take advantage of nature simulating cosmetics, color selections in wardrobes and improved dental facilities.

When it comes to teeth, however, the high school girl generally cares more for the sparkle of her teeth than avoiding a tooth ache. I really believe that if given a choice of a permanent wave, or the repair of faulty teeth, that didn't show, our sweet friend would choose the permanent. Here and now; quick returns! These are her mottoes. Guess they were ours too at that age. But why aren't we smart enough to coordinate real health with her fashion habits?

Few high school girls sleep enough. But that's a red flag and I cringe at their reaction as I write this. Of the thousands of girls I have asked, during morning sessions at high schools, "How many of you girls could sleep right now?"

never less than 100 per cent have raised their hands with a groan that sounded like "Where do we flop?" I won't debate the pros and cons, but I think fatigue and night's stimulation are not health habits—physically, mentally or emotionally—for adolescents. It doesn't solve it to ask, "Well, what are we going to do about it?" I am leading to my conclusion. We have never had an interesting or convincing health course for adolescents. I really believe the high school girl is interested in the radiance of being well. She wants to look smart and be fairly peppy. But, I think she is only faintly interested in health.

It would not take much to establish a tie-up of adolescent girls' fads and ritual "musts" with a lively, practical, quick-return health program. It's been tried before by labeling it "personality" "poise" or "what not." But, some day some one is going to designate it just as a health course and cram it full of "ready to use" health data.



Many a high school girl attends classes with headgear covering wet pin curls

Not that the high school girl wants to do a mile in zero flat; she's too svelte to work herself up to that pitch. In my day, we poo-poo'd the swooning damsel of the mauve decade. We exhausted ourselves in the physical exams. when asked to pull weights. We just didn't lift, we asked for heavier weights. We chinned ourselves until we almost collapsed. That was silly! No, the modern girl is interested in style and approval, and it happens that much of style is on the health side. I believe, though, that styles would be followed even if they weren't quite so healthy. And, I still think that an artful health course, with less dwelling on germs, bones and "innards" would snare the adolescent girls.

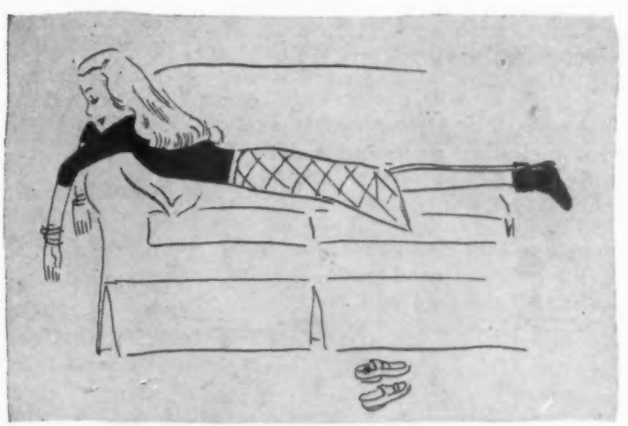
I am reminded of a dean of girls, who is commended for her health work. You can't convince me that the long discussions on cancer, for instance, that are carried on, are the correct approach. I have a feeling that a girl may either become a hypochondriac, or find the health course pretty stuffy.

I don't believe we ever made the teaching of health exciting or provocative enough for adolescents, or to any one for that matter. We are all too stuffy and cowardly to head a chapter

She combs her gleaming hair as a beauty ritual instead of a hygienic measure

with "Pimples, blackheads and popularity," or "No breakfast—No headache," or "Hair in my ice cream." Sounds and looks pretty silly, doesn't it? But, the manner in which we try to convey health education to adolescents probably seems dull to them too.

Health may be a person's most precious possession, but a health discourse can, nevertheless, be fairly boring. Let's compromise! Let's put our knowledge and ideas at their disposal. No,



Often high school girls need more sleep. Evening "dates" mean fewer sleeping hours

high school adolescents are not vitally interested in health, but they could be, if, as Dr. W. W. Bauer, Director of the Bureau of Health Education, American Medical Association, stated in HYGEIA recently, "Health could be interpreted in terms of immediate usefulness and practical common sense."

SO YOU THINK IT'S NEW!

By ***WILFRED FUNK***

Are you one of those who believe that most of the discoveries and technics in the fields of medicine and surgery have been made and perfected in comparatively modern times? And do you think that the ancients were ignorant of these technics? Then listen!

The Cesarean operation, often said to be named after Julius Caesar, was performed four hundred years before the Emperor's birth.

Burnt sponge, which contains iodine, was used to treat goiter 3,400 years ago.

In the early Christian era, Herophilus, an Alexandrian physician, was lecturing on the blood vessels and nervous system. It was he who gave our present names to many parts of the human anatomy and to most of the coats of the eye.

More than 4,000 years ago the Babylonian king, Hammurabi, established socialized medicine and fixed the fees of physicians according to the means of the patient.

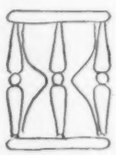
For an anesthetic, three milleniums ago, the surgeon used wine drugged with mandrake root and opium.

Four hundred and fifty years before Christ the Greek physician, Hippocrates, tied off arteries during an operation and sewed up wounds with a needle and thread.

Major operations were performed 2,000 years before Hippocrates was born. Representations of these operations, which can still be seen, were carved on stones in the city of Memphis.

A clay tablet more than 3,000 years old bears this prescription for a laxative: "The berries of the castor-oil tree—chew and swallow down with beer in order to clear out all that is in the body."

In 1,500 B. C., the citizens of Thebes were complaining that there were no longer any good old family physicians. Every one was a specialist. "The practice of medicine," writes Herodotus, the Greek historian, "is so divided among them that each physician is a healer of one disease and no more. All the country



is full of physicians, some of the eye, some of the teeth, some of what pertains to the belly."

The old time Greek doctor set fractures, adjusted dislocations, filled teeth, pulled them, and made and fitted sets of false teeth in the mouth.

The first modern looking hospital was built in Rome on an island in the River Tiber before the day of Julius Caesar. It was designed on our corridor plan, with a reception hall, administration offices, and even what seems to be an isolation ward for contagious diseases.

Fees were high nineteen centuries ago. In Rome a certain doctor, Quintus Stertinus, frequently received a fee of $10,000 for curing a wealthy patient.

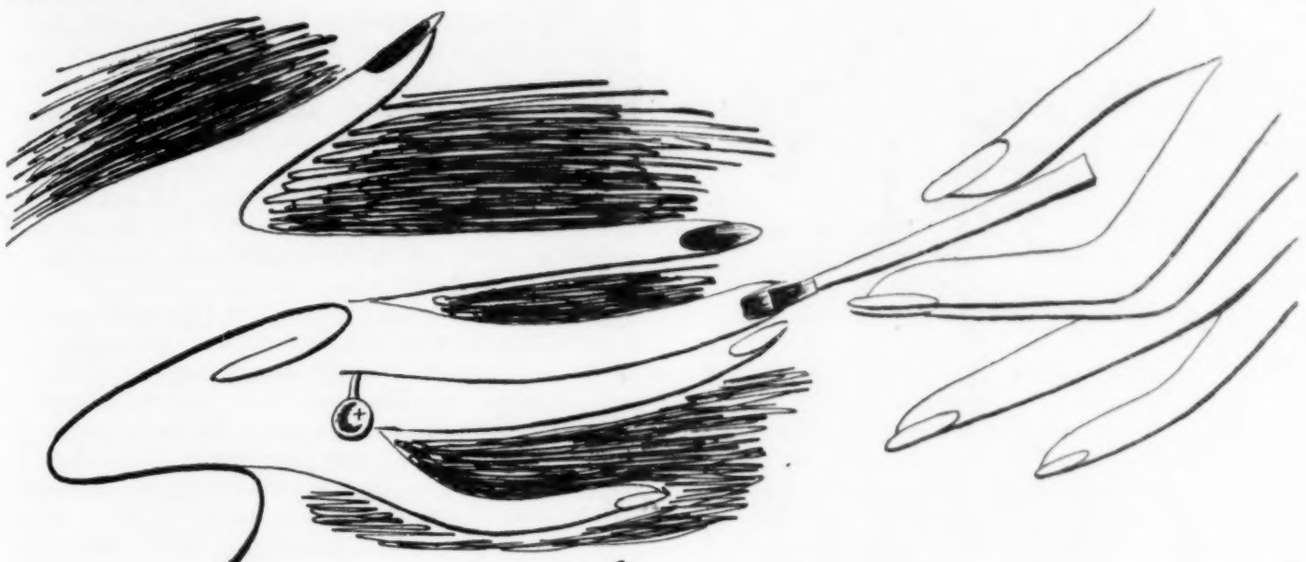
The earliest sanitarium was at Epidaurus in ancient Greece. Pa-

tients who could used a running track and worked on a punching bag made of a bladder covered with leather. Others merely sun bathed or took the waters.

The old boys were sun-bathing fans. The Roman naturalist, Pliny the Elder, who lived in the first century A. D., advises in his Natural History that "the sun is the best of the remedies which one can apply to oneself." And the disciples of Hippocrates say in effect: "It is the back, especially, that should be ex-

posed to the sun . . . for the nerves . . . are principally to be found in that region, and if these nerves are in a state of health, the whole body is rendered healthy."

Yes, these modern inventions and practices of ours, this shining civilization that we brag about—after all, they seem a little tarnished by time, don't they?



Some nails will never see red

By ELEANOR S. MORE

"NON-ALLERGIC" nail polishes are necessary for women who, in the past, could not apply nail enamel to their nails because of the common allergens present.

Hypersensitivity is not as rare as the average person may think. From 5 to 10 per cent of the population suffer from allergies. Careful examination of any cosmetic department will bring to the eye such advertised products as "non-allergic" face powder, foundation cream, cold cream, talcum powder, lipstick, face rouge, sunburn preventive, shampoo, pine bath and deodorant.

Miss Green, bothered by the usual symptoms of allergy, a rash on the face, and headaches caused by inflamed eyeballs, had gone to many doctors before she was advised by the right one as to the cause of her intense irritation.

One doctor went so far as to prescribe glasses but this was quickly contradicted by a skin specialist who said it might be the use of soap that was causing the irritation. So this "hitting in the dark" went on and on.

Nevertheless, it didn't take long for the dermatologist to diagnose the case. His questions were simple and direct. He immediately searched for and received the answer. It was nail polish!

The cure, unlike other allergies, was simple to propose. This is elimination of the causal allergen. The three methods used by many doctors are:

1. Causal allergens must be discovered and eliminated from further contact with the patient.

2. Prompt symptomatic topical treatment must be instituted in all cases, including x-ray therapy.

3. When plant and animal emanations are the etiologic agents, hyposensitization with oil extracts should be given a thorough trial.

The eyelids are one of the most sensitive areas and are often affected by many substances carried to the eyes by the hands as well as by dust, pollens, and chemicals.

The girl mentioned here, and hundreds of others in America, feel a deep consciousness about this type of allergy since many doctors do not explain the primary factor which causes such prominent swellings on the eyes.

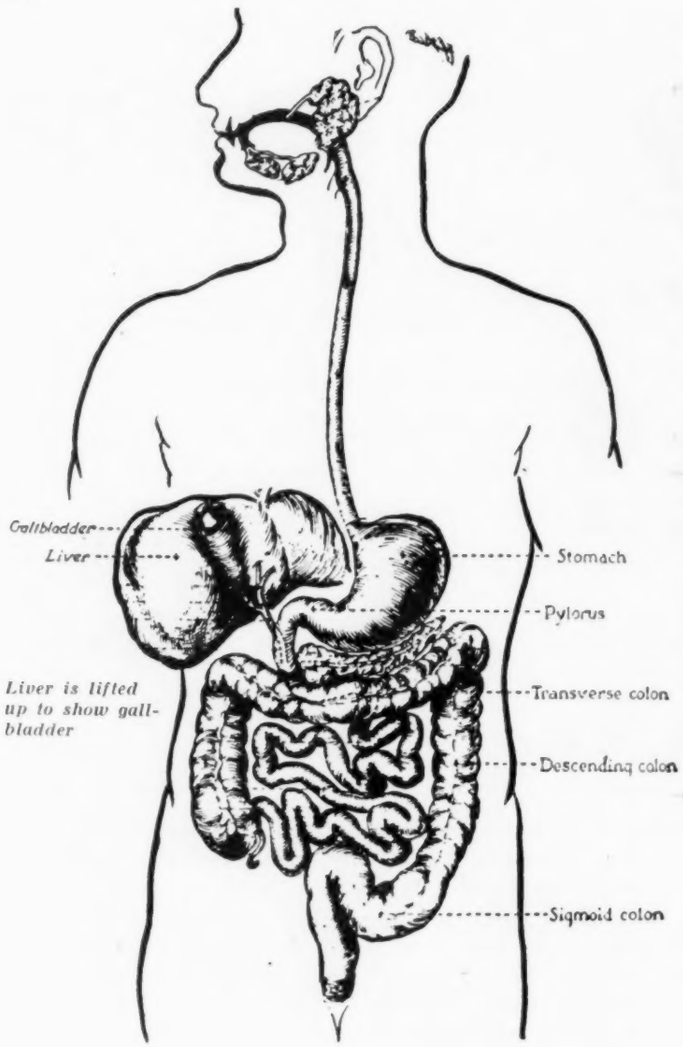
"It must be noted," said a well-known dermatologist, "that the term 'non-allergic' is too evasive to hold any meaning. A product is labeled to be 'non-allergic' because the common allergens are removed but otherwise the individual can still develop a sensitivity."

One method of fighting, and perhaps besting, this allergy problem has been suggested by various beauticians. Women seeking advice have been told that perhaps there is a deficient amount of vitamin "C" in their diet. An insufficient amount of iron is also a factor to be considered in diagnosing this allergy.

The more popular allergies, affecting the greater number of persons, such as hay fever, migraine headaches, asthma or eczema have been treated with large amounts of vitamin C by enriching the diet. However, success is not definite by any means.

The green light has been given to the scientist to go ahead on production of a nail polish which will be effective as a base, and not contain the common allergens such as stannic oxide, kaolin, zinc oxide, French chalk, pumice powder, precipitated chalk, tin oleate, and carmine or eosin for tinting.

(Continued on page 152)



CANCER
of the Digestive Tract

By JOHN J. CREEDON

CANCER is being cured completely every day in the year. Thousands of people who have had the disease are enjoying the best of health today. Delay, fear, superstition, ignorance and quackery still cause tens of thousands of cancer deaths each year among those who could unquestionably have been saved.

Twenty-five years ago the number of people dying from a ruptured appendix, with the usual resulting peritonitis, was infinitely greater than at the present time. The reason was that folks failed to appreciate and evaluate correctly their symptoms and failed to see a doctor until they reached a point where doctor and undertaker were called on practically the same nickel. However, today, education has almost obliterated this condition, and you seldom see a patient with abdominal pain who has not considered the possibility of appendicitis.

And so, with cancer, we are now trying to accomplish the same thing by having people intelligently recognize symptoms early. It is far better to suspect that you have cancer, and be told that you have not, than it is to be told that you are beyond help because you delayed too long.

The cancer problem is as old as time itself. All forms of animal, bird and fish life are subject to it. Cancer attacks either sex, and all races. Any structure or organ is susceptible. The incidence in women, however, is slightly higher than in man, due to the frequency of cancer of the breast and uterus. All age groups are susceptible, and, at present, it is the second highest cause of death in this country. Cancer is not contagious.

The term "cancer" is derived from the Latin word meaning crab. And that is just about the way it grows. It usually has a number of claws, or fingers, reaching out into normal healthy tissue. Cancer itself is made up of many cells that at one time were normal. Then for no apparent reason, they started to grow like wild fire. Some grow rapidly, some slowly; some spread quickly throughout the body, others do not; some are external, others internal. All possess the common trait of disorderly unrestrained growth. In the early stages, the cancer is small and removable. Later it either spreads to other organs or destroys the function of the organ affected. If not removed early, it eventually proves fatal. Heredity, age, injury and chronic irritations play a part in the growth of these cells.

The most common and most deadly cancer is that of the stomach. About one-half of all cases of cancer in men, and one-third of all cases of cancer in women, involve cancer of the stomach. One-fourth of all the cancer deaths reported, result from growths in this organ.

Unfortunately, because of the relatively few symptoms in the early stage, diagnosis is often a difficult one. If the cancer is at the end of the stomach, signs of obstruction may arise early and detection is easier. However, if the malignant tumor is high, the symptoms may be minor for many months.

Persistent digestive symptoms without apparent cause in anyone beyond the age of 40, should be investigated. However, the disease can and does occur at any age. Loss of appetite, gas, belching, and perhaps very mild abdominal pain, may be the only signs present. Unexplained weight loss may be the chief complaint. Later, nausea becomes a common complaint and, as the tumor grows it begins to bleed inwardly, and often a profound anemia results.

This very often may be the only clue to a malignancy of the stomach, and must always be considered during the examination of a patient with an anemia and unexplainable weight loss. Later, vomiting may occur because of the obstruction caused by the tumor mass. Severe pain, unfortunately, is usually a late symptom.

Early diagnosis must be woven from very fine threads. Most of these early symptoms, such as gas, indigestion, loss of appetite, etc., are symptoms that many people usually ignore for many months. They finally become frightened when they start to lose weight, become anemic, and have severe pain. By this time it may be too late. Cancer of the stomach, like all cancers, can be cured, but it must be diagnosed early. Any vague digestive complaint should be quickly reported to a competent physician, and a thorough investigation conducted.

By investigation we mean several things. X-rays of the stomach are still the best diagnostic measure at our disposal. The tumor usually shows up by x-ray following ingestion of a barium meal. A blood count will reveal the presence of the usual anemia associated with gastric cancer. An analysis of the stomach content will often reveal the presence or absence of acid. The absence of acid is a common finding in this disease. Physical examination may reveal a mass in the middle of the abdomen.

The treatment belongs to the domain of major surgery. It consists of removal of that part of the stomach involved.

The large bowel, which consists of the colon and rectum, is also a frequent site of cancer. Approximately 10 per cent of all deaths from cancer result from this lesion. The presence of cancer in the colon gives rise to signs and symptoms comparatively early, but unfortunately, these are also of a minor nature, and may not lead the patient to a physician immediately. These tumors tend to spread rather late in their course, and about one third of them may cause death by their local effects before they have spread beyond the point of surgical removal. The results of surgical treatment in cancer of the large bowel are better than those for any other type of cancer of the digestive tract. Although the lesion may occur anywhere in the large bowel, the left colon is the most common site.

The right colon is a continuation of the small intestine and is mainly concerned with the absorption of food materials and water. The left colon, with its strong muscular walls, is mainly concerned with storage and excretion of waste products. The symptoms of cancer vary, depending on whether or not it is located in the right or left half of the colon. Men and women alike are susceptible, and age distribution is like that of all cancers, although the group between fifty and sixty is most commonly affected. But no age is immune, not even those in their teens.

The early symptoms of cancer of the colon are usually insignificant. An interval of about eight months usually elapses before symptoms become severe enough to force the patient to seek the help of a physician. The duration of the disease has a direct relationship to the success of surgery, and, therefore, to the percentage of cures. Fatigue, weight loss, increasing constipation, vague indigestion, and anemia, are all important warning signs. Many of these symptoms seem minor in nature, and are apt to be overlooked. This is particularly true of lesions of the right colon which may give no evidence of their presence. Here the first symptoms may be those resulting from anemia, since these tumors bleed readily. Because a cancer at this site rarely obstructs the bowel, there may be no associated symptoms other than some indigestion. However, diarrhea alternating with constipation is occasionally seen. Blood in the stool may be an ominous sign.

Tumors of the left colon often draw attention to themselves early by a slowly developing obstruction producing colicky low abdominal pain. On the other hand, the obstruction may be sudden in nature with no antecedent manifestations. In this latter case, the pain will be acute and usually associated with nausea and vomiting. Blood and mucus in the stool are common findings later on. The early signs are, however, usually vague and nondescript.

It should be emphasized that during the stage when there appears to be nothing but mild abdominal distress—distension, constipation, or indigestion—the percentage of cures is relatively high. Later, when the signs of obstruction appear with bleeding, anemia, and weight loss, the tumor has spread and the chances are less hopeful.

Early investigation is to be encouraged. The x-rays are again the greatest aid in diagnosis. A barium enema will show the point of obstruction early. On physical examination, the tumor may occasionally be felt, particularly if it is low in the region of the rectum. Laboratory "work-up" may reveal anemia, and blood in the stool. The treatment is invariably surgical with removal of the involved segment of the bowel. The operative mortality in skilled hands is now very low. Certainly it should be under 10 per cent. The reported average of surgical cures in cancer of the colon is between 40 and 50 per cent.

Our hopes of increasing the percentage of cures in cancer rest with the patient. Many people would be alive today had they heeded the early signs of their disease. Surgical technic has been greatly improved. However, a physician can do nothing with a patient who presents himself too late. Those who have had symptoms for a year or more and have consistently ignored the disease in its early stages are usually beyond the point of cure. The hope for better results lies in early diagnosis so that surgery can be carried out before the tumor spreads.

My Operation

By BERNADINE BAILEY

WAS I scared? The word is a gross understatement. The night before the operation I would have walked out of the hospital and never returned, if the nurse hadn't placed my clothes under lock and key. Over and over I kept telling myself: There's nothing to it; thousands go through it every day, even people who are critically ill; you're in excellent condition, there's nothing to fear; stop being a sissy. Nevertheless, I was afraid, horribly so.

Above all else, I dreaded that "last mile," the trip to the operating room, with its antiseptic odors, intense lights shooting down from strange angles, gleaming metal reflectors, trays of polished instruments, tanks of gases for anesthesia, and sterile whiteness. I shrank from the thought of being held on the operating table, having a mask clamped on my face, and being told to count! The different kinds of unpleasantness that would follow the operation—nausea, weakness, gas pains, surgical shock, removal of

stitches, adhesions, etc.—didn't prey on my mind nearly so much as my horror of the steps that would precede the ordeal.

From the moment when a well meaning friend had characterized that fateful trip to the operating room as crossing the "Bridge of Sighs," my imagination had worked overtime, boosting blood pressure and pulse beyond all reasonable ceilings. Those who have gone through it know what I mean, and as for those who haven't—it is for them that I'm writing this article. If some one had only told me all that I eventually learned—the hard way—I might have been spared nine tenths of my worries and would have embarked on my venture in a vastly better mental—and possibly physical—condition. The whole procedure seems so commonplace to doctors that many of them never think of explaining it beforehand to the patient.

As it turned out, I didn't suffer even five minutes of pain or unpleasantness during the entire seventeen days in the hospital! Not one of the actions or sensations I dreaded came to pass—not even the terrifying "Bridge of Sighs." And no nausea, no gas pains, no undue weakness, no slightest twinge when the stitches were removed. What a lot of energy I had wasted in needless worry! Hence my eagerness to tell others about the preventive technics that make for safe surgery today. The procedures described here apply to most abdominal operations, on either men or women.

Make sure, first of all, that you select a capable surgeon. There are various ways of checking

—and Yours

his technical reputation: by consulting your local medical society or the local hospital; by writing to the American Medical Association (535 North Dearborn Street, Chicago) or consulting their directory (where all members' names are listed in capitals, and where surgeons are indicated by a special designation following their names) in the public library; or, as a double check, by writing to the American College of Surgeons (40 East Erie Street, Chicago), or by ascertaining that your surgeon has the certificate of the American Board in Surgery. If the surgeon you have in mind is not known to any of these groups, it would be well to seek some one who, by reason of his education, experience, and ethical standards, is recognized by the medical profession itself.

I chose a woman surgeon. When I found that she was a member of the American College of Surgeons, was on the staff of some of Chicago's best hospitals, and was also certified by the American Board of Obstetrics and Gynecology, I felt satisfied that I was in capable hands. It is absolutely essential to have complete confidence in the person who wields the knife. In no other human relationship is faith more important than between patient and surgeon. It might be well to add, right here, that you must be willing to trust your surgeon's judgment as well as his operative skill. Don't bind him, beforehand, with ironclad promises to do certain specific things. Until he has actually opened the abdomen, no surgeon can know the exact condition of the internal organs. That is the reason he must be given latitude to follow his best judgment when he sees what the situation really is. And don't be disappointed if the operation doesn't follow your own preconceived blueprint. You aren't the doctor!

Regardless of whom you finally select to do the operating, it may be well to have a second opinion as to the necessity for the operation. Any reputable physician will welcome another opinion on your case; it protects him as well as you. There is no reason to feel nervous or embarrassed about getting a second opinion. Sometimes the doctor himself will suggest it.

Once you have chosen your surgeon, and it has been definitely settled that you need an operation, take some time (if your physician agrees) to get yourself into the best possible physical condition. This is where the coolly calculated operation, often called "elective surgery," has advantages over the emergency job in which one is rushed to the hospital with a "red hot" appendix or a strangulated hernia that must be taken care of at once—or else! Planning the event well in advance is obviously safer than taking pot luck on your body's powers of recuperation. Your doctor will give you specific instructions, but in general you will want to get an abundance of sleep, eat vitamin-rich foods (especially milk and orange juice), avoid overexertion, and forego alcohol and tobacco (if you have the will power). Above all, don't worry!

As for hospital arrangements, such de luxe trimmings as a private room, special nurses day and night, and similar services, are not only virtually impossible to get, but are fortunately not essential to a rapid recovery. Having spent my entire seventeen days in a four-bed ward, I know whereof I speak. The first two or three days you are completely indifferent to what goes on; after that, you are glad to have some one in the room with whom to speak.

If you look forward to the operation as a vacation, with no responsibilities, no worries, no standing in endless lines, no arguments about the missing laundry, etc., you'll find that it can be a very pleasant experience. Take several gay books with you, but not too gay, for laughter is uncomfortable and not advisable.

Many surgeons make a practice of entering the patient in the hospital approximately forty hours before the operation, to allow ample time for testing and resting. For example, I entered at 5 p. m. on Tuesday, and was operated on at 8 a. m. on Thursday. In *(Continued on page 132)*

OBESITY

By HERBERT SCHREIER

OBESE, or overweight, people are neither to be pitied nor laughed at. Excessive weight, in most cases, is a health hazard; life insurance studies prove that excessive weight tends to shorten life.

The danger of overweight shows itself in many ways. Exaggerated shortness of breath on exertion, and other signs of relative insufficiency of the heart, are invariably observed in seriously overweight people. These are due, for the most part, to the mechanical impairment of circulation and respiration.

A definite relationship exists between blood pressure and body weight. Convincing observations show the fall of blood pressure following the reduction of excessive weight, and a rise of blood pressure again after weight, previously lost, has been regained. Some obese people may have normal or even low blood pressure, but there are constitutional types predisposed to both obesity and high blood pressure. In such people there is a nutritional and functional relationship linking these two conditions.

Overweight is an unfavorable factor in the recovery from pneumonia. More postoperative pneumonia occurs in overweight persons. Obesity may also aggravate attacks of bronchial asthma and reduction of weight may, in such cases, be followed by considerable relief. Stomach complaints are often associated with continued consumption of heavy meals. The relationship of gallbladder disease and gallstone formation to excessive overeating, with resulting obesity, has been well established.

Wherever there is diabetes in the family, it becomes imperative to prevent overweight. There is a lowered inherited body insulin reserve in these people, and their excessive intake of refined starches, lacking enzymes and vitamins, and excessive fat intake, may cause definite damage to their livers, and place a strain on already weakened insulin mechanisms, precipitating diabetes. The prevention of diabetes lies in the field of weight reduction of obese prediabetics.

Women obese since childhood gain excessively during and following pregnancy. Obstetricians generally recognize that overweight pregnant women are threatened with more serious complications at delivery and after delivery than pregnant women of normal weight. Toxemia of pregnancy is most frequently associated with excessive weight.

Postural neuralgias, arthritis and backaches are caused or aggravated by overweight; skin manifestations are common. Heat loss through conduction and radiation is lessened in the obese because of the insulatory effect of fat deposits under the skin. In regions where the skin folds come together, friction may result. The moist skin may become macerated and eczema, with superimposed fungus growth, may result.

Surgeons realize that a patient's excessive

weight increases the risks inherent in major operations. Postoperative complications are more common, too, in obese patients. Many surgeons insist that preceding a nonemergency operation the patient's weight be reduced.

Last, but not least, there is a mental factor in psychic trauma or insult, with manifestations of an inferiority complex. Many patients, in throwing off the shackles of gustatory sensualism, regain self confidence.

The most important aspect of obesity, or overweight, is the problem of caloric balance, or the increase of caloric intake over caloric output. Of course, there are other aspects of obesity to be taken into consideration including the fields of internal secretion, particularly the pituitary; neurology, especially the midbrain; involved cellular physiology (fat mobilization and fat deposits), and genetics, with hereditary predisposition to constitutional types.

The involved body weight regulatory mechanism has been compared with body temperature, blood pressure, and blood sugar regulations; while mobilization and transport of fat deposits in the body are subject to endocrine glands and the midbrain. People who are obese have a

Gain of excessive weight is accompanied by a decrease in caloric output of the body. Contrary to popular belief, manifest thyroid deficiency is rare in obesity. The lessened caloric output of the patient with an underactive thyroid gland leads to excessive body weight only when the appetite stays at a relatively high level. The pituitary gland and the midbrain are considered of greater importance in the disturbed weight regulatory mechanism.

Some so-called glandular disturbances are a sequel of obesity rather than its cause. Menstrual difficulties are present in the obese, and are often corrected by adequate treatment of obesity with submaintenance diet and vitamins. This is often a nutritional rather than a glandular problem.

In the majority of cases, the treatment of obesity must, of necessity, be limited to measures directed against the product of the disturbed body weight regulation.

Loss of excess weight may be made without harm to the health of the patients, provided they fulfil the following requirements: maintain caloric value below caloric output, protein content sufficient to prevent undue loss of tissue

• • • • A HEALTH HAZARD

disturbance of this weight regulatory mechanism, and must be careful not to disturb the caloric balance.

An obese person, who on a low caloric diet loses excess weight, and with continued restriction of food intake, maintains normal body weight, is in normal caloric equilibrium. The anomaly that caused the obesity persists, however, and the patient may deposit fat rapidly if he resumes his former eating habits.

The degree of overweight is usually a measure of the amount of overeating. Many obese people, because they sincerely believe that they are not large eaters, mention with hope and longing the possibility that some glandular disturbance may be the cause of their excessive overweight; their mental makeup resembles that of chronic alcoholics.

Hunger must be differentiated from appetite. Hunger is an unpleasant sensation of tension or pressure, dizziness and nervous irritability; it is an organic demand. Appetite is a pleasant desire for food, accompanied by memory impressions of sight, taste, and smell. Appetite may be intensified or weakened by habit and training.

Obesity is a habit and dangerous at that. When obese people say they do not eat much, they usually refer to bulk, rather than food value. Accurate investigation of the food values will prove them wrong. To illustrate: 100 grams of lettuce gives 20 calories, 100 grams of concentrated starch gives 400 calories, while 100 grams of concentrated fat gives 900 calories.

protein, enough starches to prevent acidosis (disturbance of alkali reserve), sufficient amount of minerals to prevent demineralization of the body (particularly calcium and phosphorus) and enough vitamins to guard against vitamin deficiency and liver damage.

During the period of dietary treatment, the patient acquires a better voluntary control of appetite and, in a good many cases, there is actually a decrease in appetite as a result of the prolonged conditioning to which the reflex appetite mechanism has been subjected.

Obese patients can be kept on 600 to 900 calorie diets indefinitely, without any harm as long as excess fat is present. The average reducing diet consists of about 100 grams of protein, 100 grams of carbohydrate and ⅔ gram of fat. Submaintenance diet may be deficient in calcium unless care is taken to include adequate amounts of fruits, vegetables, milk and cheese.

Due to the usual restriction in the submaintenance diet of butter and cream, reducing diets may be deficient in vitamins A and D. Mild vitamin B deficiency has also been observed, and there is a preparation known as a Therapeutic Vitamin Capsule, which contains all the necessary vitamins and a dosage of one capsule daily is sufficient. The treatment should be started with diet, minerals and vitamins, and small doses of thyroid can be added when weight becomes stationary.

(Continued on page 130)

Arthritis and

THE terms "arthritis" and "rheumatism" are not interchangeable although their meanings overlap. "Arthritis" means an inflammation of a joint. "Rheumatism" means discomfort and disability from a disease of the locomotor system and includes arthritis, bursitis, fibrositis, myositis, gout, lumbago and other similar diseases.

Rheumatism is derived from the Greek word rheum or rheuma, meaning a watery discharge. The connection of rheum to joint disease was obviously based on the swelling of joints due to rheum or a watery collection in the joint. Arthritis stems from "arthros" and "itis," the Greek words meaning joint and inflammation. This combination is also to be found in appendicitis, tonsillitis, sinusitis and bronchitis.

Joint disease is as old as history. It is the most common, disabling, expensive and devastating, economically and socially, of all the chronic ailments to which man falls heir. But before discussing this ailment it might be well to first consider normal joints.

A joint is a connection between two bones. Movable joints are the ends of bone made smooth and slippery by the glistening surface of cartilage moistened with normal joint fluid. They function as a ball and socket, such as the shoulder and the hip. Or, they may serve as a hinge, swinging only in one plane like the knees, ankle and elbow. In other instances the bone may slip over the surface of another bone as occurs in the knee cap or joints in the back of the spinal column.

The nonmovable joints are the teeth, the sutures of the cranium and the cartilaginous disks between the vertebrae. While the nonmovable joints are vitally important, this article is confined to a treatment of movable joints and to a discussion of how arthritis affects them. While there are several types of arthritis, rheumatoid arthritis will be discussed first.

Rheumatoid arthritis is a chronic joint disease, more common in women than in men, which begins usually in the twenties or thirties. The disease begins slowly, so slowly and gradually that the patient dates the onset in terms of months or years rather than days or weeks. There is stiffness and soreness accompanied by joint swelling. The joints may be involved singly or together, symmetrically or not, severely or mildly. Joint swelling is due to the collection of fluid in the joint space and the thickening of the tissues surrounding joints. Loss of muscle strength, decrease in muscle size and limitation of muscle endurance in the region of the involved joints occur in various degrees and may develop rapidly. The hands and feet may become cold and clammy, often actually dripping with perspiration, and the skin may appear blue, leading one to believe "circulation is poor."

There may also be a deterioration of general health. Victims suffer from fatigue, easy exhaustion and loss of appetite and weight. They became anemic and are susceptible to changes in temperature and humidity. Rheumatoid arthritis is a chronic constitutional disease of unknown origin affecting many organs and systems of the body.

Ankylosing spondylitis is a form of rheumatoid arthritis which attacks the spine. A disease common in young men, it is manifested by backache, eventually resulting in stiffness of the spine and a bowed back. The joints of the arms and legs are spared, however. It runs an active course in one to ten years after which time the patient regains his general health with the exception of the mechanical disadvantage of a stiffened spine.

Patients frequently state that they do not expect this stiffness to leave until the calcium deposit in the joint is dissolved. Calcium is not deposited in the joints in rheumatoid arthritis. X-rays have proven that in the early stages of the disease there is a severe loss of calcium in the affected bones. Consequently, any attempts to move the bone may break it as it is weak. In the spine, bony stiffness of the spinal joints is followed by calcification of the ligaments enclosing the intervertebral disks resulting in a condition doctors term "bamboo spine."

Many patients with rheumatoid arthritis may fulfil normal social and civic obligations with more or less difficulty for years. It is, however, the disease most likely to cripple, leaving its victim chair bound or bedridden with complete stiffness and fixation of joints, with legs sharply drawn up at the hips, acutely bent at the knees, the back stiffened, the neck bent forward, the jaws locked, the elbows flexed and the hands uselessly gnarled.

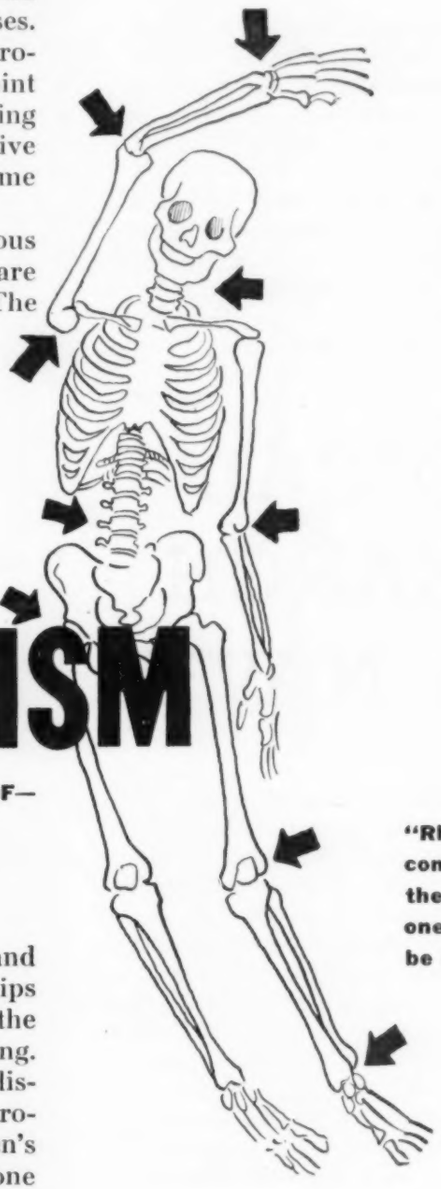
Degenerative joint disease has features in striking contrast to those of rheumatoid arthritis. As the name implies it is a sort of wearing out process associated with injury and advancing age. It may develop following a joint injury such as dislocation, fracture or gunshot wound. It may follow repeated attacks of gout or result

By
ROBERT M. STECHER

RHEUMATISM

(INCLUDES ALL TYPES OF—

ARTHRITIS
BURSITIS
FIBROSITIS
GOUT
LUMBAGO
AND OTHERS



"Rheumatism" means discomfort from a disease of the locomotor system, and one of those diseases may be arthritis

from nervous conditions such as locomotor ataxia or syringomyelia. The susceptibility of people for this disease is related to their age. This is so true that anthropologists and scientific detectives, when determining the age of unknown skeletons, rely heavily on the presence and the severity of degenerative changes. The agreement of incidence to age has been proven many times by studies of large groups of people by x-rays of knees, hips and spines, by examination of human joints after death and also of the joints of cattle in slaughter houses. Many of the changes revealed by these procedures are the results of degenerative joint disease which have never proven discomforting to the patient. It is obvious that degenerative changes start slowly and progress for a long time before the patient is aware of them.

Degenerative joint disease occurs in vigorous and robust people, especially those who are overweight. It attacks both sexes equally. The large weight bearing joints such as hips and knees are frequently involved. When the hips are involved, lameness may be severe, as the disease causes stiffness, soreness and creaking.

A particular form of degenerative joint disease, involving the end joints of the fingers, produces a knob-like enlargement called Heberden's nodes. Many people, particularly men, have one or two fingers enlarged as a result of competitive athletics. Another hereditary type starts in one finger and spreads to the other fingers. It is transmitted from mother to daughter.

Daughters may inherit it from their fathers, but men, although they transmit the trait, do not often show it. They show it only when they inherit it from both parents and then they transmit it to their daughters. These rules of heredity are not readily apparent because the deformity may not develop until 50 or 60 years of age, consequently many people inherit and transmit it without ever knowing it. Heberden's nodes is the only form of arthritis to be affected by heredity with the exception of gout and rheumatic fever.

Degenerative joint disease of the spine is known as spondylosis. The bones of the spine may become so enlarged from injury or hard work that the spinal column is completely stiffened. In fact, this ailment is sometimes called the workingman's spine. Small spurs, or pieces of bone in the spine, are often noted by x-rays in examinations for other diseases. These spurs are so common in people over 50 that they must be looked upon as average even though they cannot be considered as normal accompaniments of the aging process.

However, degenerative joint disease may occur as a result of gout. This disease is characterized by severe, *(Continued on page 142)*

GUAM—(Delayed)—Naval Medical Research teams are still waging a relentless fight against disease on the one-time battlefields in the Pacific.

Naval Medical Research Unit No. 2, only organization of its kind in the world, boasts a staff of 44 officer-scientists, about 250 enlisted technicians and service troops and a "campus" of about 62 buildings at the main base of Guam. Many of the buildings are air conditioned and all are supplied with modern scientific equipment.

All these facilities were organized by Captain Thomas M. Rivers, Medical Corps, USNR, a white-haired Georgian who is a nationally-known authority on infectious diseases, and director of New York's Rockefeller Hospital of the Rockefeller Institute.

"This is a research laboratory which was established as near to the fighting front as possible," Dr. Rivers explained. "Only by doing research under the actual conditions which produced tropical diseases could we thoroughly investigate the causes and devise cures."

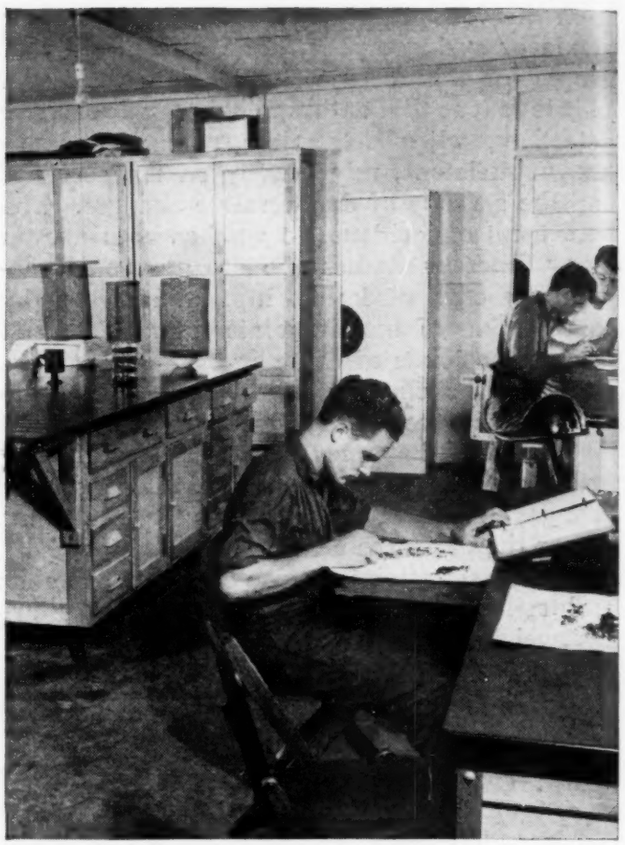
MEDICAL RESEARCH in the NAVY

Location of the Naval Medical Research Unit here was no accident, for Guam is the medical center of the Pacific, and the unit works in cooperation with the many Army and Navy hospitals on Guam. According to Marine Major General Henry L. Larsen, island commander, "the Naval Medical Research Unit is a vital part of the most scientific and efficient medical service the Navy can provide, bringing to the zone the very latest discoveries in the prevention and cure of disease and injuries."

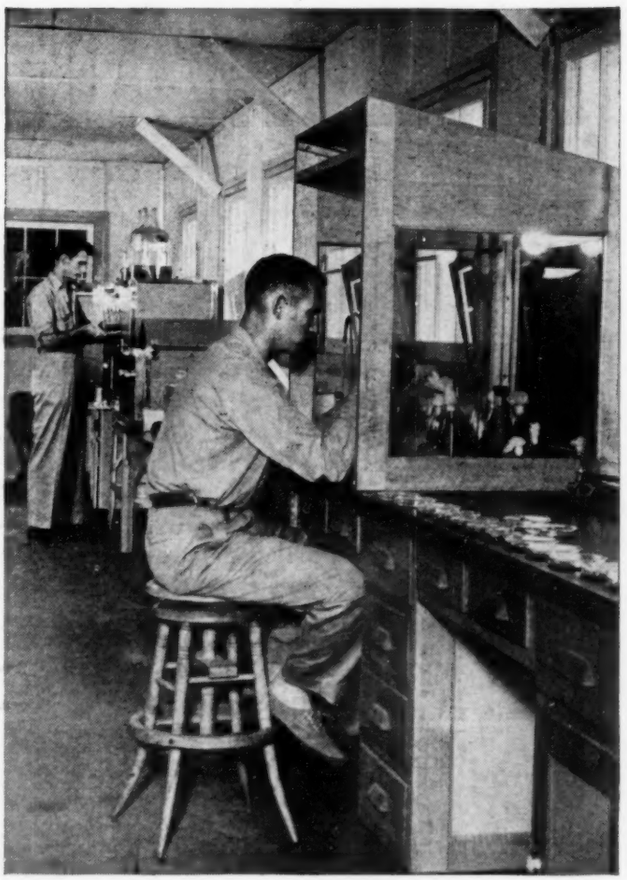
Here is a partial picture of the unit's achievements:

(1) Scientists of the unit were the first to use large-scale sprays of insecticide in the Pacific. (2) They tested and first utilized the miracle insecticide DDT under combat in the Pacific. (3) Members of the unit pioneered in the examination of snails as disease carrying agents. (4) In the laboratory, scientists are trying to raise mites—carriers of the dangerous scrub typhus, through the life cycle, something which has never before been accomplished. (5) In the huge field laboratory, certain species of flies are being raised under observation for the first time.

The present Naval Medical Research Unit grew out of a group of about 15 of the Rocke-

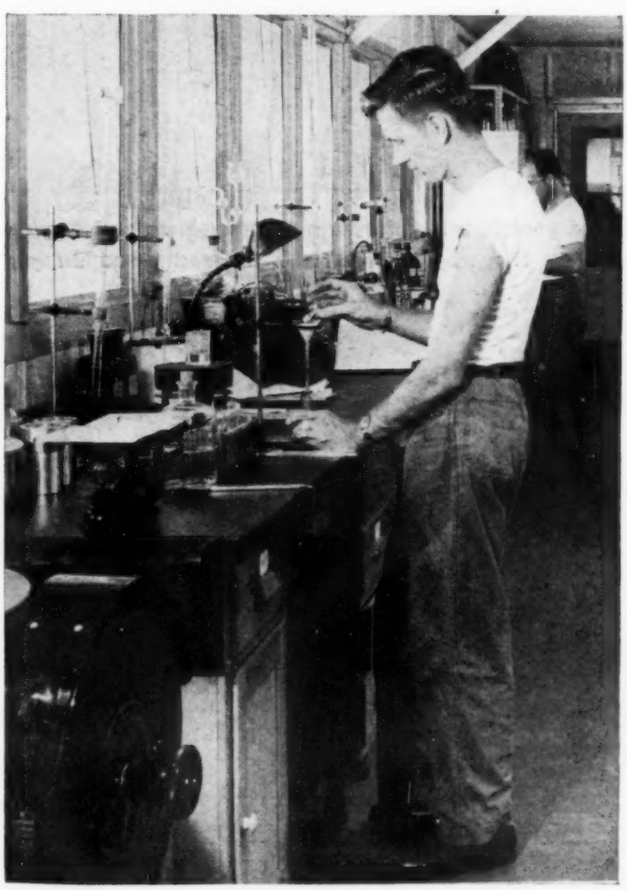


In the entomology laboratory of NAMRU No. 2, the common fly is one of the subjects of intensive study



Mammalogy, acarology, chemistry, bacteriology and malariology laboratories are in operation on Guam

The navy's medical research unit boasts a staff of 44 officer-scientists and 250 enlisted technicians



By doing research under the conditions which produce tropical diseases, causes and cures are being sought

feller Hospital staff, headed by Dr. Rivers, who went into the Naval Reserve in 1940 to do research on scientific subjects for the government. When war broke out, all facilities of the hospital were turned over to the Navy under a dollar-a-year arrangement.

In 1943 two diseases, infectious hepatitis (jaundice) and scrub typhus, were causing considerable trouble among American troops in the South Pacific, and Dr. Rivers was sent by the Navy to that area to make a survey. As a result of his report, it was decided to form the Naval Medical Research Unit to attack these diseases at their source—the Pacific area. Work on these problems is continuing today.

"We started our work with the full cooperation of the Navy Surgeon General, Vice Admiral Ross T. McIntire, who called scientists the unsung heroes of any naval action," Dr. Rivers said. "Admiral McIntire emphasized that science must be the backbone of any steps the Navy takes, and that meant research. The Naval Medical Research Unit helped win the war by saving the lives and health of many American fighting men, but no less important was the material contribution it made to the sum knowledge of medical science."

As late as 1944, DDT was next to unknown in the Pacific NAMRU No. 2 introduced DDT for field use in the Navy, conducting experiments on mosquitoes and flies, and giving indoctrination in its use. In cooperation with the Department of Agriculture, the unit tested DDT on

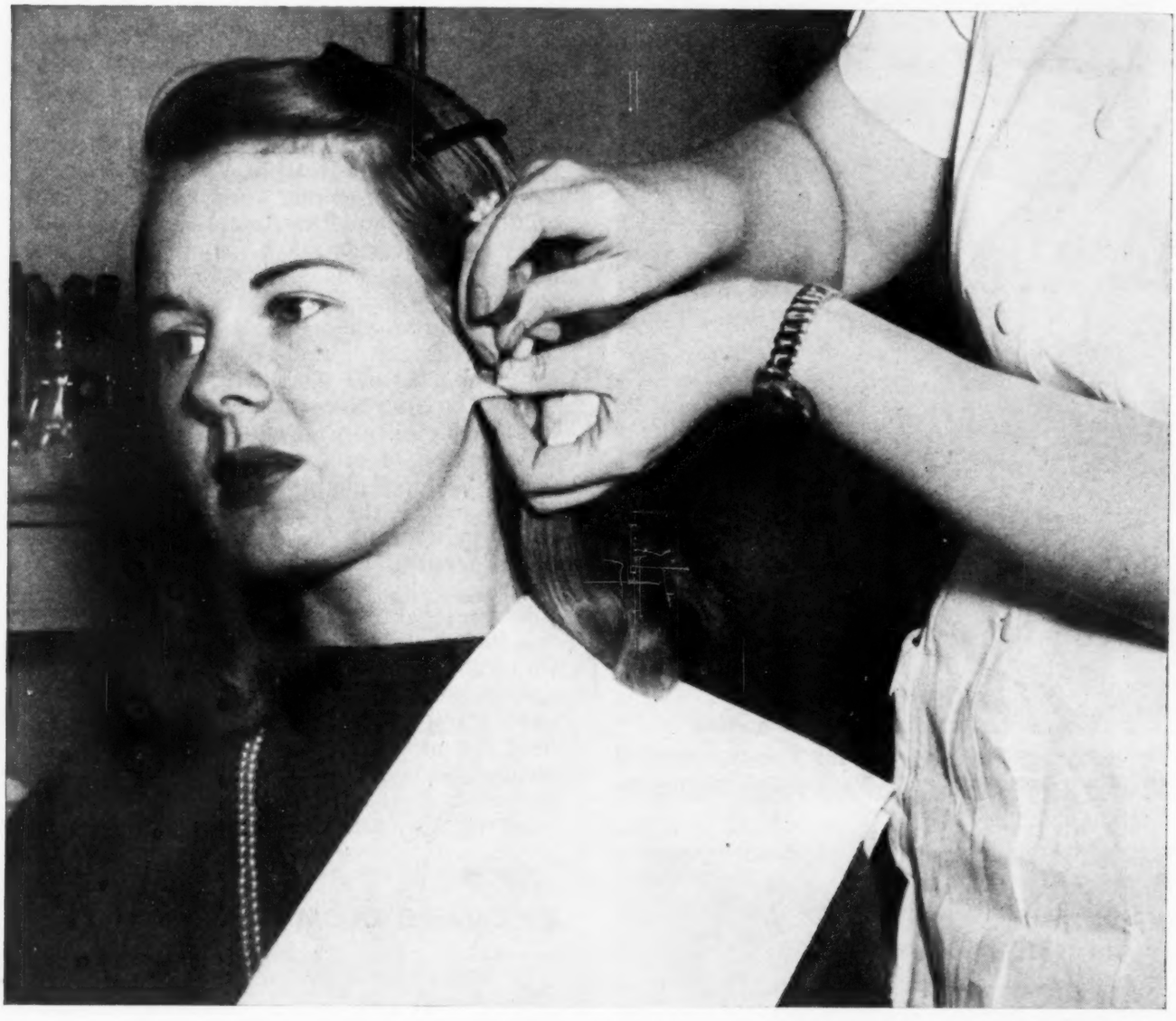
By Corporal ODOM FANNING, USMC

Guadalcanal and Bouganville, and was first to use airplane sprays in the south Pacific.

"We are proud, too, of our accomplishment in first using DDT under combat in the Pacific," Dr. Rivers said. "In August, 1944, members of our unit went ashore on Peleliu to protect the men of the First Marine Division against the many diseases carried by insects susceptible to DDT."

Many months later, in April 1945, three of the unit's staff accompanied assault forces in the landings on Okinawa, "where malaria, dengue and dysentery could easily have claimed more casualties than the Japs." These men were frequently under fire and bombings, and one scientist, Lieut. John D. Maple, H(S), U.S.N.R., of Whittier, Calif., was killed in an airplane crash while directing a spraying operation. In repulsing an attack on their field laboratory, scientists of the unit killed three Japs. Ten officers and 20 enlisted men were left on Okinawa, studying every phase of the medical and health problems found there.

A detail from the malacology department, now in the Philippines, is making a special study of snails in relation to blood flukes, which carry schistosomiasis, a poten- *(Continued on page 151)*



Accurate blood counts will determine the presence and degree of anemia. It is the way to ascertain the red blood supply

What Do You Know About

By HUGH A. and CORNELIA M. CARITHERS

TIRED? Run down? No energy? The cause may be anemia that is impairing the efficiency of thousands of Americans. The cases that will be discovered in the war scarred countries of the world will no doubt run into the millions. Here are some scientific facts about anemia. How many do you know?

ANEMIA MEANS LACK OF RED BLOOD.—True. An anemic person may have a shortage of red blood cells or he may have a normal number of red cells with insufficient red coloring matter in them.

ANEMIA IS A NEW DISEASE, A PRODUCT OF OUR CIVILIZATION.—False. As early as 1670, Sydenham, an English physician, recognized anemia and used iron to treat the disease. Earlier medical records also mention anemia. Liver treatment of pernicious anemia is, however, a recent American discovery.

HEMOGLOBIN IS THE SUBSTANCE IN RED BLOOD CELLS THAT MAKES THEM RED.—True. It is a complicated protein which transports oxygen and carbon dioxide, containing iron, traces of copper and other essential substances.

UNLESS LOST BY BLEEDING, RED BLOOD CELLS BECOME A PERMANENT PART OF THE BODY.—False. Blood cells are constantly dying as new ones are being formed. The average life of a red blood cell is probably less than 3 months.

RED BLOOD CELLS USUALLY INCREASE WITH INFECTIONS.—False. It is the white blood cell count that increases with most infections. In many infections, particularly with "strep" germs, the number of red blood cells is reduced.

MOST BABIES ARE BORN WITH MORE RED BLOOD CELLS THAN THEY NEED.—True. The blood count of the newly born is usually higher than it will ever be again. Red blood cells destroyed during the first days of life provide iron which is stored in the liver.

PALENESS ALWAYS MEANS ANEMIA.—False. While paleness may be caused by anemia, all pale persons are not anemic. Some persons with sufficient red blood cells and hemoglobin appear pale because their blood vessels do not allow the blood to reach the surface of the skin. In many persons the red blood must be reduced almost 50 per cent before the pallor of anemia can be noticed.

ANEMIA CAUSES NO SYMPTOMS.—False. In mild anemia cases, weakness and tiredness symptoms usually develop after a few weeks. Unless corrected in children retarded development may occur. Moderate anemia often results in shortness of breath, heart murmurs, swelling of feet and ankles, and headaches. Severe anemia sometimes causes numbness, enlargement of the abdomen, deafness, pale or yellow skin, and enlargement of finger tips.

ANEMIA?

"COLD NATURED" PERSONS ARE MORE LIKELY TO BE ANEMIC THAN THE AVERAGE PERSON.—True. A lack of red blood may cause an increased sensitivity to low temperatures.

YOU CAN DETERMINE IF A PERSON IS ANEMIC BY LOOKING AT THE RED LINING OF THE EYELIDS AND MOUTH.—False. If the anemia is severe, there may be enough loss of coloring to cause a strong suspicion, but one cannot be absolutely sure.

THE ACCURATE WAY TO DIAGNOSE ANEMIA IS BY A BLOOD COUNT.—True. An accurate blood count determines the presence and degree of anemia. It is the only way to determine the presence or lack of red blood.

MOST CASES OF ANEMIA OCCUR BECAUSE OF LACK OF IRON IN THE DIET.—True. It should be remembered that anemia caused by lack of iron—often called secondary or nutritional anemia—while the most common, is only one of at least twelve different types. Anemia caused by severe infections, pernicious anemia, anemia from hemorrhage, malaria, hookworm and syphilis are a few types not associated with iron deficiency.

AN ANEMIC PREGNANT WOMAN MAY TRANSMIT THE DISEASE TO HER CHILD.—True. A baby is dependent on the mother's supply of iron and other essential elements to build red blood. A child born to an anemic mother may not be anemic at birth, but without sufficient iron stored in his body he is likely to develop the disease during his first year.

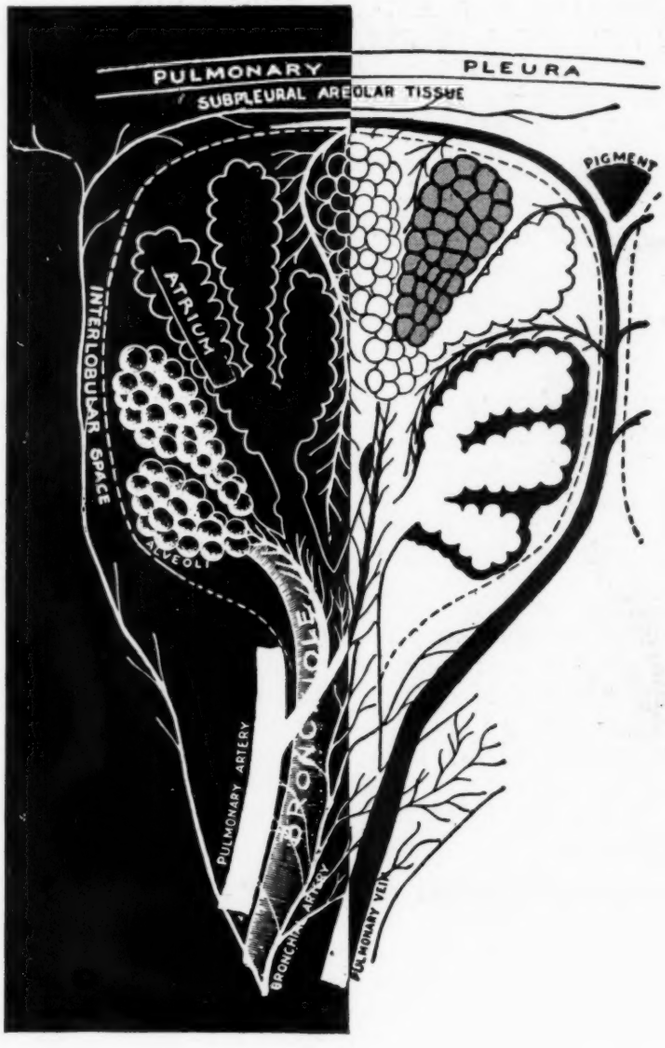
A PREGNANT WOMAN WITHOUT ANEMIA CANNOT HAVE AN ANEMIC CHILD.—False. There are rare types of anemia that may be transmitted by a nonanemic mother. Hereditary factors, not improper diet nor indiscretions during pregnancy, are the cause. One type is found only in persons of Mediterranean stock. The cause of another type, called erythroblastic anemias, has recently been discovered. Transfusions in infancy usually control this inherited anemia.

IF A NORMAL CHILD TAKES ALL THE MILK HE SHOULD, HE WILL NOT BECOME ANEMIC.—False. While containing traces of iron, milk is poor in this vital element. A newborn baby usually has enough iron to meet his needs for several months, but unless solid foods containing iron are started before 8 or 9 months anemia will probably develop.

LIVER MUST BE INCLUDED IN THE DIET TO PREVENT ANEMIA.—False. Liver contains a substance necessary for the control of pernicious anemia, a disease of middle and old age, but it is not a necessary item of the diet. It is, however, a good food, rich in iron.

IT IS EASY TO PROVIDE AN ANEMIA PREVENTIVE DIET, RICH IN IRON.—True. Foods richest in iron include whole grain cereal, egg yolk, liver, lean meat, peas, beans, dates, prunes, raisins, rhubarb, soybeans, spinach, and beets, mustard and turnip greens. Broccoli, brussels sprouts, string beans, asparagus, potatoes (white) and nuts are also rich in iron.

SPINACH SHOULD BE INCLUDED IN EVERY DIET BECAUSE IT IS AN ANEMIA PREVENTIVE FOOD.—False. While spinach does contain iron, it is far from being richest in this element among green leafy foods. It should not be forced upon children.



Workers in industry who come in contact with irritants to the lungs may develop chronic irritation of the air passages

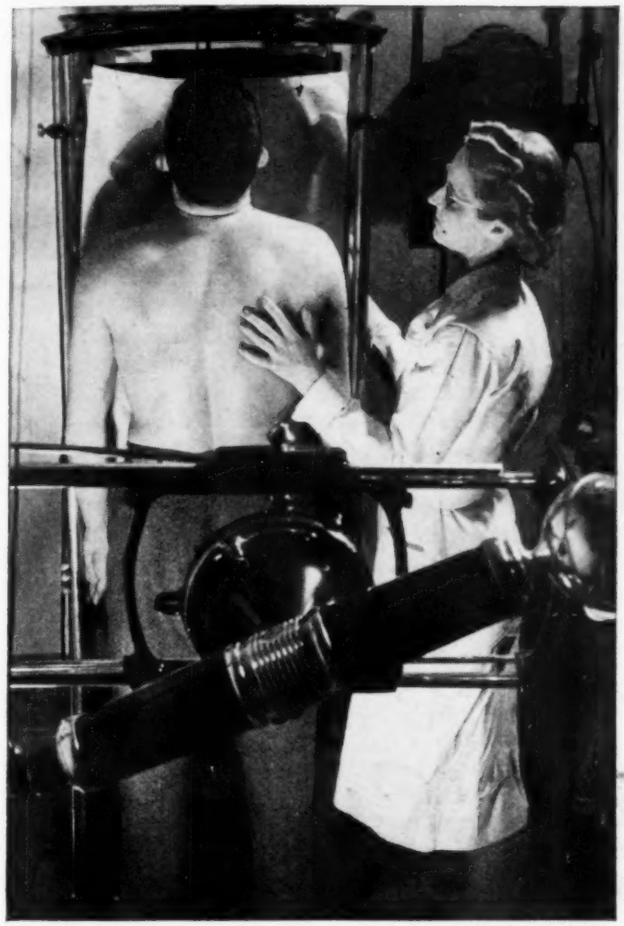
CHRONIC BRONCHITIS

By ARTHUR S. WEBB

OFTEN one hears another say, "I have chronic bronchitis." Such a statement is made with the thought that chronic bronchitis is something that must be borne and further investigation is unnecessary. Too often this diagnosis is picked up by the patient from the busy physician who in prescribing for the patient may mention chronic bronchitis. The patient, realizing that his aunt had chronic bronchitis and lived for years with a cough, assumes that chronic bronchitis is his lot and does nothing further about his complaints. Years ago these cases were often spoken of as catarrh.

Within the last decade, physicians have learned much about lung diseases. X-rays have played a most important part and other laboratory and office procedures have been utilized. We know that chronic bronchitis may indicate other diseases which are dangerous to the individual or may be dangerous to those about him, such as tuberculosis. The acceptance of the diagnosis of chronic bronchitis, without a systematic study of the patient, may be dangerous to the patient and embarrassing to the doctor. Careful physicians who do not obtain results from the usual office procedure with patients who have a bothersome cough will make a careful study of the case to arrive at a specific diagnosis. A condition known as chronic bronchitis can exist, however, and the reason for the chronic irritation should be sought.

There are many causes for chronic irritation of the bronchial tubes. An irritation may begin with the acute diseases such as measles, whooping cough, influenza, pneumonia, typhoid fever, scarlet fever, malaria, or infected tonsils. Bad



Torkel Korling

Chest x-rays may indicate special films are needed to study the shape and size of the bronchial tubes and air sacs. The nose and throat should be examined

teeth or sinus infection may play a part. Other conditions which may be uncovered on investigating chronic bronchitis are tuberculosis and bronchiectasis. Bronchiectasis is an enlargement and infection of the tubes and air sacs of the lungs. Rarely syphilis may be a cause.

Workers in industry who come in contact with various irritants to the lungs can develop a chronic irritation of the air passages. If the worker is exposed to dust that has sand particles of small enough size to breathe into his lungs, he can develop a condition known as silicosis, in which particles of sand enter the lung and cause eventually irritation and cough. This need not occur if proper precautions are taken.

Deformities of the air passageways, such as enlarged tonsils, adenoids and enlarged turbinates (these are the little folds that are seen on the outer side of the nose when one looks into the nose), may contribute to chronic bronchitis. Also, foreign bodies, such as beans, that children may stick up the nostrils, and polyps, tumors and various other unusual conditions may encourage chronic infection of the air passages.

Patients who suffer from allergy, that is those who are sensitive to pollens, grasses or even the cat, dog or parrot, may develop chronic bronchitis. Sometimes food or house dust can cause some individuals to develop symptoms of sneezing, coughing and running of the nose. Musicians who use wind instruments may develop bronchitis.

The most common cause of chronic bronchial irritation is the cigaret. Some individuals are very sensitive to cigaret, pipe or cigar smoke. It is foolish for these to continue the habit of smoking.

We can deduce from this that chronic bronchitis can have many causes. A study of the patient should be made to discover and remove the cause. If due to tuberculosis, the patient's life may be saved or many other lives may be saved from a dangerous disease that the chronic bronchitis sufferer has spread without knowing.

If due to abnormal conditions in the lungs or air passageways, these may be removed and the patient saved from a life of semi-illness which cramps his efficiency and is disturbing to those about him. A neglected chronic cough, with its irritation and infection, may cause changes in the lung which may eventually cause a change in the shape of the chest. Such people are more or less semi-invalids. They are susceptible to cold, fatigue, loss of weight and appetite. They may be able to work but do not feel well.

In investigating such a problem, an orderly procedure should be followed beginning with a careful history with particular attention to past diseases and occupational hazards. Questions regarding the aspiration of foreign bodies are important. The nose and throat should be examined. X-rays of the sinuses and lungs should be taken. Perhaps the doctor will want to study the bacteria in the nose and throat. Certainly the sputum should be examined. The x-rays of the chest may indicate that special films are necessary for further study such as instilling oil into the bronchial tubes and then taking the x-rays to study the shape and size of the tubes and air sacs. Examination of the patient under the fluoroscope is helpful. Sometimes the bronchoscopist may be called in consultation. He is an expert in examining the interior of the air passages in order to discover disease, tumors, or foreign bodies. If there is a suggestion of allergy or sensitiveness to something, the patient should have appropriate tests.

Treatment for chronic bronchitis depends on the cause. It is easy to see from this brief article that chronic bronchitis may be a complicated problem. Have patience with your physician. Let him be the detective to ferret out the cause of the chronic cough. It may mean a richer and longer life for the fellow who just has chronic bronchitis.

By JAMES S. GREENE

Hope for the Stutterer

SOME years ago, an archeologist, excavating the ruins of the Biblical town Beth-shemesh, came upon a small clay tablet. On it was engraven a prayer: "Oh God, cut through the backbone of my stammering. I desire that thou shalt remove the spring of my impediment."

The cry of that ancient and nameless speech sufferer has echoed and re-echoed through the centuries. Every age has had its quota of speech cripples. Some of the more illustrious names of the roster of speech sufferers are Moses, Aristotle, Virgil, Charles Lamb, Clara Barton, founder of the American Red Cross, Andrew Mellon and the present King of England. Even Winston Churchill had a speech defect in his earlier years.

Today there are in the United States over 13,000,000 speech and voice sufferers, a number exceeding the combined populations of all the New England states. Of these, about 1,300,000 are stutterers.

The stutterer is among the most seriously handicapped of all speech sufferers—much more seriously handicapped than many of us realize. Stuttering is a nervous affliction. Because this is not generally understood, little has been done to help the stutterer. Over and over again, I receive letters like this one from a boy in Connecticut. He writes: "I have stuttered since childhood, and it is spoiling my whole life. Is there any hope that I can overcome this affliction? Isn't there anything that can be done for boys like me?"

The 1,300,000 stutterers in the United States comprise about 1 per cent of the population—a group of unfortunates at least twice, and possibly three times as large as the number of deaf and blind combined.

Of these people, there are about 4 or 5 male stutterers to every female stutterer. Possibly the reason that girls are less susceptible to stuttering than boys is due to the fact that the female of the human species is, in many respects, stronger and more stable than the male.

The cause of stuttering is not known. But observations and research studies indicate that certain children are born with a nervous constitution predisposing them to the disorder. They are termed "stutterer-type" children.

These children may go along without any trouble unless some shock or accident precipitates the disorder. Sometimes a fall or bad fright disorganizes the child's nervous system and is associated with the onset of the stuttering. Again, the speech disturbance can be precipitated by quarrels and tensions in the home. Occasionally, it may come on suddenly after the

birth of a younger brother or sister. An addition to the family may make this type of child unconsciously fear that the new arrival will displace him in his parents' affections. This undermines his feeling of security and has the same effect as any other psychic shock.

In other words there are two factors in the causation of stuttering—an underlying constitutional predisposition toward the disorder, and some more immediate psychic factor that precipitates the speech disturbance.

We, who have made studies of stuttering, have come to the conclusion that while stuttering itself is not inherited, there is a predisposition to the disorder—the constitutional susceptibility to this type of disturbance is probably inherited.

In 65 per cent of the cases, stutterers came from families in which a parent or other relative has the same disorder. Stuttering usually begins in childhood, and in 90 per cent of the cases it begins before the age of 6 years.

Stuttering may begin when the child leaves the comparative security of home, to begin school. This is quite an event in a child's life and can be a rather terrifying experience for a timid, sensitive youngster.

Some parents believe that a child may outgrow stuttering. This is definitely not true. Stuttering isn't simply a bad habit that time will cure—it is a nervous disorder. It is a signal that the child is meeting some situation, or is under some strain, with which his nervous system cannot adequately cope. Only about 10 per cent of the children who stutter overcome it without assistance.

Too, the time to arrest stuttering is when it first begins, rather than later in life when the child has developed anxiety and feelings of inferiority and inadequacy about it.

In the early stage of stuttering treatment is largely a matter of eliminating the environmental factors that are placing a nervous strain on the child. Often stuttering can be arrested at this point by the simple expedient of getting the mother to put suggestions into practice in the home.

The most important of these suggestions to mothers is to "slow down the tempo of living in your home." Many parents of stuttering children are human tornadoes. They speak and work rapidly, and, in fact, do everything in "high." The child's organism is not geared for this rapid tempo, and in trying to imitate it, he loses his coordination and rhythm—and this is manifested in his speech. So, the guiding motto in the home of the stuttering child should be "slow—easy."

Another relevant suggestion is to avoid continually correcting the child when he stutters. This will only make him speech conscious and increase the severity of his disorder. Instead, encourage him to talk, and to do everything, slowly and easily. And, above all else, parents should set the stuttering child a good example by speaking in a slow tempo themselves.

Never punish a stuttering child—hoping to break him of the "habit"—as many people believe it to be. One mother who brought her 7 year old son to the speech clinic had become so angry with him when he stuttered that she had banged his head against a table. Her excuse was that he had conversed all afternoon with a playmate without stuttering, and she couldn't understand why he had to stumble over his words when he spoke with her. He was merely being stubborn, she maintained.

Treatment like this will only aggravate the stuttering habit. For stuttering is a nervous condition—and not a habit over which the child has voluntary control. He may be able to speak perfectly at one time and then, a few moments later, depending on environmental circumstances, he may scarcely be able to utter a word. Punishment in such cases is sheer cruelty.

Stuttering, like many other nervous disorders, is confined to certain types of people. A highly excitable and nervous child may be more susceptible to stuttering than a calm, even dispositioned child—that is, he may be a stutter-type child. Too, a watchful eye should be kept on the child who comes from a family in which there already are stutterers.

A grandmother asked an interesting question in a letter recently. Her grandson stutters. The child was originally left handed and she wanted to know if making him use his right hand as a baby was the cause of his speech disorder.

Although there probably is no underlying relationship between left and right handedness and stuttering, a child who is made to use his right, instead of left hand, is being forced to do something contrary to what nature intended for his particular organism. This, of course, puts a strain on his nervous system. If the child has inherited a predisposition toward stuttering, it is possible that this strain will be severe enough to bring on the disorder. In other words, it may act as a precipitating shock.

Only a small percentage of children whose handedness has been changed actually stutter. Nevertheless, for many reasons, no attempt should be made to change a child's handedness. Let it develop as it was intended—nature always knows best.

While stuttering children, in many cases, respond to home treatment, the adult stutterer requires expert help in a speech clinic. The adult stutterer is in the second stage of the disorder, in which the element of anxiety is pronounced to the point of being an actual neurosis. Stuttering in the secondary phase is a great deal more difficult to treat because it is necessary to influence the entire personality. This requires a many sided form of treatment—medical, psychiatric, psychologic, reeducational and social. It must be carried out by trained clinicians under the supervision of medical specialists.

By JOSEPHINE BESSEMS

"SORRY, can't use you in this picture." It was an old story to the young man who had been vainly haunting Hollywood's motion picture casting bureaus for months. Finally, a compassionate casting director told him he would never succeed in pictures because of his crooked teeth. Today, his name is up in lights throughout the country, and his flashing smile is familiar to movie fans everywhere. Few people suspect that his even teeth, seen on the screen, are a dentist's work of art.

Your mouth and teeth are among the most important factors in your personal appearance. Beautiful eyes, skin and hair count for little when combined with protruding jaws and ugly teeth. But you don't have to go through life with dental handicaps. Except in rare cases, correction is possible.

Johnnie had what the dentists term an open bite. His upper teeth protruded beyond the lower teeth. He just couldn't close his front teeth or his lips. His mouth hung open and he looked stupid, although actually he was as bright as any average boy. But Johnnie was selfconscious, indifferent, had few friends—his parents and teachers called him "difficult." When he reached eighth grade, an understanding teacher persuaded his mother to consult an orthodontist (a dentist who specializes in straightening teeth). One day, after Johnnie had been undergoing treatment for about a year, he dashed into the dentist's office happy as a lark.

"Doctor," he said, "I ate a sandwich last night with the other fellows! I never could before."

Even the dentist, working with similar cases every day, hadn't fully realized what it had meant to this boy not to be able to take a bite out of a sandwich or an apple. Previously his food had to be cut or broken into bits and chewed by his back teeth. His was a severe case. He had worried so much about it that eating a sandwich with the gang had become, to him, the ultimate goal of achievement.

Children are thoughtlessly cruel, all too ready to single out a child with malformed teeth or jaws as an object of ridicule. Many an unhappy youngster endures, with a brave front, the humiliating nickname of "Tusky" or "Long Jaw" or "Tombstone." Taunted and laughed at, he shuns strangers and frequently becomes a behavior problem. As he grows older, the deformity is apt to become worse instead of better. His personality may develop "queer" quirks which may handicap him throughout life.

Most dental deformities can be corrected, or at least improved, but prevention is much simpler than correction. For this reason, children should make their first visit to the dentist as soon as all of the first set of teeth have made their appearance, usually at the age of about two and one half years. Checkups at regular intervals thereafter will reveal defects before they become serious, when correction is comparatively simple.

"So, the school dentist says my Dolores should have fillings in her teeth," wrote an irate mother to a first-grade teacher. "Now I want you to know I'm not wasting money on teeth that are going to fall out soon anyway. You mind your own business and teach Dolores her lessons."

Dolores' decayed baby teeth were not filled. Two of them developed abscesses and were lost prematurely. Her permanent teeth came in crooked. Later on, Dolores' parents spent several hundred dollars having them straightened —trouble and expense which could have been avoided if her first teeth had received proper dental care.

Baby teeth give form and symmetry to the child's face and act as guides for the permanent teeth that are forming beneath them. When a baby tooth is lost prematurely, the teeth on either side have a tendency to drift together and partially close the vacant space. Then, several years later, when the permanent tooth is ready to come through, there isn't enough room in the spot where nature intended it to be, so it stays locked in the gum, or may push its way through high up on the gum. If a dentist had seen Dolores soon after her first tooth was lost, he could have inserted a space maintainer—a small metal appliance which fills the gap and holds the teeth on either side in place. Space maintainers, which are easy and inexpensive to install, preserve the jaw line and often save lengthy and costly corrective work later on. Sometimes a baby tooth stays in the mouth longer than it should, and the permanent tooth appears either in front of or behind it, causing irregularity in alinement which could have been

avoided if the dentist had been given an opportunity to extract the tooth at the proper time.

Dentists don't always agree as to the effects of thumb-sucking. Most of them concede, however, that pronounced thumb-sucking, especially if continued until the fifth or sixth year, may result in jaw deformities. Lip sucking, tongue and cheek biting, or any unnatural facial habit, if too long maintained, may cause distortion. Mouth breathing due to enlarged tonsils may interfere with normal development of the jaws, too.

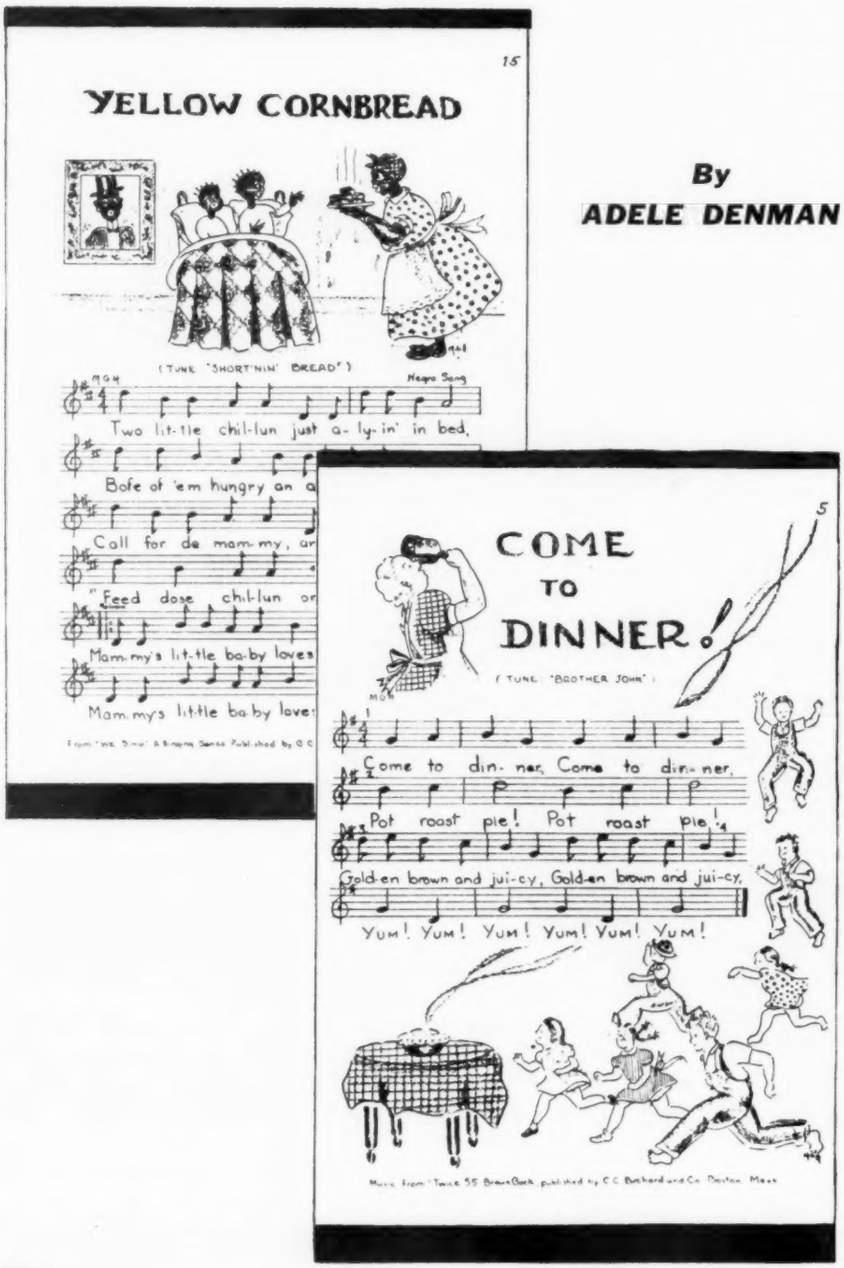
Not all dental deformities are preventable. Some are present at birth. Mankind seems to

Personalities Remade— By the Dentist

be afflicted with a high incidence of dento-facial deformities, compared to the frequency of malformation in the rest of the body. Almost 90 per cent of white persons have some malocclusion (failure of the upper and lower teeth to meet properly). Scientists believe that man's jaws are growing smaller more rapidly than his teeth are decreasing in size or in number as man goes through evolution. Frequently there isn't enough room in the jaw for the entire complement of teeth, so they push each other out of place, and the result is crookedness and crowding.

All dentists encounter patients who have never acquired the normal number of teeth. They also see, although less frequently, patients who have teeth in excess of the normal thirty-two. These extra teeth may erupt anywhere in the jaw and may cause irregularities by pushing aside the normal teeth. Occasionally, for no apparent reason, teeth run wild and appear outside the jaws. A midwestern university dental clinic had a patient with nine superfluous teeth growing all over the roof of his mouth. Cases are on record in which teeth have appeared in the nose, or even as far away as the eye socket. Oversized teeth are not uncommon. Frequently x-rays reveal impacted teeth, often lying crosswise in the gum, unable to come through without assistance. For these and other abnormalities modern dental science has developed methods of correction to improve function and appearance.

There are, in the United States, close to two thousand practising orthodontists. Orthodontists move or tip teeth through the aid of appliances such as bands, fine wires and tiny screws, so designed as to exert pressure on the teeth in the direction in which they are to be moved. Such appliances need to be adjusted frequently. After a tooth has been moved, cemented bands hold it in place during a "retention" period, while it becomes firmly *(Continued on page 153)*



By
ADELE DENMAN

FOOD ON THE TABLE OF CONTENTS

THE bare cupboard of Old Mother Hubbard, depressingly familiar to generations of youngsters, is no longer bare in the minds of Kentucky mountain children. It has been filled with food, grown and canned by Mother Hubbard's children right on her own farm. And the songs that Little Tommy Tucker sang for his supper have been filled with words telling of crisp brown pot-roast, steaming hot cornbread, and heaps of fresh green vegetables.

This transformation of old nursery rhymes is a phase of a significant experiment in food education—an experiment based on the theory that Mother Goose can be more than merely pleasant reading for young people. And, in practice the theory hopes to prove that the old reading, writing and arithmetic wasted a lot of effort when it failed to teach more than to read and write and figure.

This educational theory maintains that the exercises, illustrations, and stories used in school work should convey indirectly to the pupil many facts which will help him in solving the basic problems of existence—food, clothing and shelter. Separate projects on these three phases, made possible by grants from the Alfred P. Sloan Foundation, are now being conducted in Kentucky (food), Vermont (clothing) and Florida (shelter).

The experiment on food, conducted under the direction of the Bureau of School Service in the College of Education at the University of Kentucky, will take several years to produce widespread results. In the meanwhile, the Bureau has written a new kind of textbook for rural schools—books about gardening, canning, and cooking explaining how better foods may be provided on the farms and in the homes of the young readers. The pupil learns to produce and eat the foods as he learns to read. Through him his family may learn also.

The six-year food improvement campaign is having its effect on the mountain children especially, as evidenced by working garden projects in the schoolyards, under supervision of the teachers.

In 1939, when the experiment in children's literaure was begun by the Bureau, a first-grade primer was prepared entitled "We Make a Garden." This was a feeler to test teacher reaction, and to influence as many children as early as possible. The plan was to follow the primer with books for higher grade-levels. The Bureau hoped in this way that the school curriculum, in a few years' time, would be saturated with materials concerning diet.

The subject of gardening was too broad to cover in one book, however, and a series of eight books called "Food From Our Land" was written. These traced the process of gardening from plowing the soil to canning the vegetables.

The next series of ten books, entitled "The Smith Family," was prepared for second-grade level. It told the story of a family that was forced by economic necessity to make a living from the farm. They plan and plant a garden, build a fish pond, plant grape vines, transplant fruit and nut trees, make sorghum molasses, and start a colony of bees. It is no accident that these are precisely the things which an Eastern Kentucky family could do if forced to make a living from the depleted soil of the hills.

The crippled child in the family is taken to the hospital, on the advice of a county health officer, where he grows well and strong. When he comes home, telling of the hospital diet, his father buys a milk goat so that he may have the food he needs.

In the last book of the series, "Fun at the Fair," the family wins prizes on the food they have grown and the baby wins prizes for being the healthiest child in the baby contest.

When interest in the set led to demands by teachers for more information on some of the subjects, a science reader was written for the

(Continued on page 126)

Everybody's Favorite!

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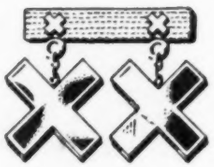


THE DOUBLE CROSS
For Disobedience to Orders . . . unbecoming a patient.

POISON OAK CLUSTER
For Selfishness . . . utter disregard for the personal feelings of others.

WHEN doctors find it necessary to take patients off coffee—here's a routine that makes everyone happy. It's easy to "play ball" with your doctor when his helpful advice is "Drink Postum instead." Postum contains no caffein, no stimulants of any kind—yet it's a hearty, comforting, full-bodied mealtime drink with a distinctive taste all its own. Postum is a favorite with millions because Postum gets along with everyone. You'd be surprised at the people who *can* drink Coffee who *prefer* delicious Postum.

Postum

—ONE OF AMERICA'S GREAT MEALTIME DRINKS

Food on the Table of Contents

(Continued from page 124)

upper elementary grades. This book, "Sweeter than Sweet," gave further information on the making of molasses and the care of bees.

Another device used in bringing food to the attention of the children is an intermediate language workbook with exercise sentences concerning the Smith Family. Sentences to be filled in with the correct tense of the verbs eat, cook, grow, and plant teach both grammar and food.

The original plan of the Bureau was to show teachers how they could write and illustrate children's books for their own use in solving individual community problems in food and other subjects. Later, the burden of writing and illustrating was assumed by the Bureau, which selected experienced teachers in rural schools to come to the office and write the low-priced books, which could be ordered by other teachers as the need for them was created.

This phase of the work of the Bureau is a part of the Sloan Experiment in Applied Economics. It is financed by a grant-in-aid given to the University of Kentucky in 1939 by the Sloan Foundation.

Children like the stories in the books distributed by the Bureau, for the characters live on farms like themselves. The parents of the children in the books are like their mothers and fathers, and the subjects deal with foods that they might grow and eat.

The subject of food, assigned to the Bureau was lucky indeed, for Kentucky, as a proving ground, was in need of food education. Also people became more interested in food during the war, and the Bureau's work not only became more timely in a popular sense, but it assumed a greater importance in the minds of teachers.

Now the Bureau is continuing its work with even greater vigor, for they have realized the full importance of the need for food education. Some day they hope to prove that the experiment with children's literature helped to solve many of the childhood problems of men and women in the future generation.

SURGICAL NURSE

She moves in white . . .
Mystic, shadowless in the clear light
Of the operating room.
Among the shining needles,
The curved forceps,
The unsheathed knives,
In all that enchanted forest
Of clean cut steel
And silvered sharpness,
Her fingers
Are softly, and delicately . . . at home.

—Florence Layton Rumry.

ARE YOU 1,000 YEARS OLDER THAN YOUR CHILDREN?

By BERNARD HIRSHBERG

CHILDREN like to feel that their parents are looked upon as up-to-the minute folks who are right in the swim of things. They experience a sense of shame when mother and dad are considered old fashioned. If the home environment is that of musty, dead yesterdays, youngsters feel that their parents are 1,000 years too old.

Are you 1,000 years older than your children?

Test yourself with the following guide-questions. Turn to page 128 for the "control" answers.

1. Are you the last one in your town to accept the latest scientific food preparations?

2. Do you consider it foolish to modernize your kitchen, because you work on the theory that what was good enough for your grandmother should be good enough for you?

3. Do you believe that if you spare the rod you will spoil the child, or are you in sympathy with the modern theories of child guidance?

4. Are you averse to joining a Mothers' Club, a Reading Circle or similar community activities?

5. Do you still get a "kick" out of a family picnic?

6. Have you become set and opinionated, or can you still be convinced?

7. Do you condemn the modern generation, its dress, its frankness and independence?

8. Is your favorite expression "What is this world coming to?"

9. Do you think your children are growing up like weeds because their latest dance step is an imitation of sheer savagery, compared to the Charleston you helped popularize?

10. Are you worried about the fact that Junior is strong on memorizing the names of news commentators and band leaders, and weak on memorizing his poetry memory gem?

11. Do you still experience a feeling of wonder when you see an unusual flower, a red dawn, a smiling child?

12. Are you sometimes tempted to put on an old hat and walk out in the rain—for the fun of it?

13. When your child finds a pretty sea shell or a bird's nest or a turtle, can you match the child's feeling of ecstacy or do you now take the wonders of nature for granted?

14. Do you make a fuss about your child's excellent report card, or has everything become humdrum?

15. Do you ever take stock of yourself and decide to visit a beauty parlor or do you always come back to the same old position that the facial can wait but the housework cannot?

16. Do you find the rocking chair so comfortable that "going out" isn't worth the effort?

17. Are you happy that time flies or do you feel that you haven't enough time to do the things you have planned?

18. Do you feel elated when the birds return from the South and the buds peep out, or is it merely a matter of a change in weather, for you?

19. Do you look back to the good old days, or does tomorrow still hold out a promise, that "joy cometh with the morning?"

20. Is your theme song, "Turn Back the Universe and Give Me Yesterday," or "There Are Bluebirds over the White Cliffs of Dover, Now that the World Is Free?"

Turn to page 128 for answers

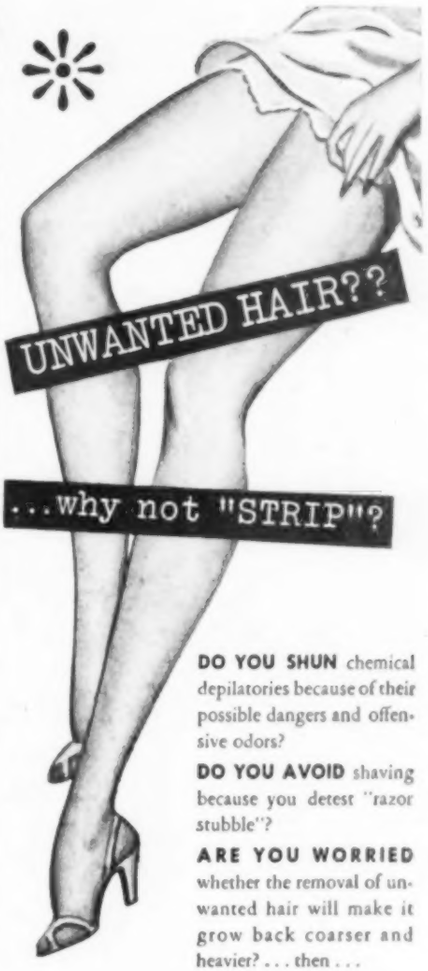
Dr. Aesop's Fables

The Cock and the Jewel

A cock, scratching for food for himself and his hens, found a precious stone; to which he said: "If your owner had found thee, and not I, he would have set thee in thy first estate; but I have found thee for no purpose. I would rather have one barleycorn than all the jewels in the world."

A man, purchasing a small farm in a mountain place, that his wife and daughter might regain their health, was suddenly notified that oil had been found on his property, and that he was rich. "Ah," he said sadly, "if someone else had this news, he could be glad, but it means nothing to me. I would rather see my loved ones restored to health than have all the riches in the world."

W. W. Bauer.



DO YOU SHUN chemical depilatories because of their possible dangers and offensive odors?

DO YOU AVOID shaving because you detest "razor stubble"?

ARE YOU WORRIED whether the removal of unwanted hair will make it grow back coarser and heavier? . . . then . . .

Strip Cosmetic Epilator is YOUR solution

Strip is a bland wax-like compound totally free from dangerous and ill-smelling chemicals. It is NOT a chemical depilatory.

Strip helps remove hair, safely and swiftly, by "Stripping" unwanted hair from above and below the skin surface, leaving skin clean and smooth, without any bristly hair stubbles.

Strip Treatments give freedom from unwanted hair from 4 to 6 weeks, varying with individual hair growth.

Strip will NOT make the hair grow back coarser or heavier.

Strip is Proud and Happy to be the first product of its kind to be accepted for advertising in publications of the American Medical Association.

Strip Epilating Treatments At The Finer Beauty Salons From Coast To Coast

Strip
COSMETIC EPILATOR

Reg. U. S. Pat. Off.

Manufactured by STRIP, Inc. Division of Gayla Cosmetics Pittsfield Bldg., Chicago, 3, Ill.

What to do about a "MILK REBEL" ... try the Carnation way

Here's a 7-point plan for getting your child's milk-quota into every day's diet.

1. In tempting milk shakes.
2. In rich cream sauces and soups.
3. In smooth ice creams and frozen desserts.
4. In appetizing, milk-rich recipes.
5. With double the richness of whole milk, as it pours from the can . . . on cereals, fruits, and puddings.
6. Whipped for dessert and fruit topping.
7. In delicious drinks, mixed half and half with cold water and flavoring, or with fruit juices.

Carnation Milk is good whole milk that is concentrated to double richness, then homogenized and sterilized for easier digestion and safety. The 400 vitamin D units in each reconverted quart supply the approved daily requirement.

Carnation is the milk that has given millions of babies a splendid start in life—and there's no need to change when formula days are over.

Keep your *growing* child right on his same good milk . . . Carnation.

Free! For real help in getting your child's milk-quota into his diet, send for Carnation's booklet, "Growing Up With Milk." There are dozens of delicious milk-rich recipes for baby, growing-ups, and grown-ups, with hints about feeding them. *Address Carnation Company, Dept. 740-A, Milwaukee 2, Wis.*

Listen! Music America Loves
The New "CONTENTED HOUR"
Every Monday Evening—147 NBC Stations

Carnation Milk

"FROM CONTENTED COWS"

Answers to

ARE YOU 1,000 YEARS OLDER THAN YOUR CHILDREN?

(Continued from page 127)

1. Shame on you! You can save yourself worry and work in food preparation if you follow the latest scientific developments. The question of balanced diets, nutritive values, proteins, fats, carbohydrates, vitamins, leads to one answer: If you would guard your children's health acquaint yourself with latest food discoveries.

2. Human progress dates back to the time some primitive announced that what was good enough for his grandmother was not good enough for him! Keep in step—modernize your kitchen and save yourself waste-motion.

3. If you use the rod you will get obedience, but not self-discipline; fear, and not affection; lip service, but not confidence.

4. When a girl can say "My mother belongs to the Mothers' Club," she is wearing a badge of honor. Children like to feel that their parents belong to important things.

5. If you cannot grab a knapsack, containing sandwiches and a thermos bottle, and hit up a frolicksome pace with the kids, for a family picnic—look out, soon you will feel 1,000 years older than your children!

6. A set mind is a closed mind. Listen to the other side, weigh and consider. If the opposition presents a good case there may be something fallacious with your opinion. Find the flaw—and change your mind.

7. Every generation finds fault with the succeeding one. Remember Post World War I with its Flaming Youth? That was the generation that defied and overthrew Hitlerism! Do not judge any generation by its dress. The present generation will, in good time, take its stand—for freedom, democracy and a world for the common man!

8. Why not change it to—"What a beautiful world to come!"

9. Fashions come and go—and dance steps. Perhaps the older generation finds fault with the latest dance step because it cannot keep up with the new pace. On with their dance!

10. Children these days are alert to current events. The movies, telephone and the radio have catapulted the children into the world. They are more news-conscious than they are aware of the poetry that was alive in a dead, mauve decade.

11. A sense of wonder keeps alive the feeling of beauty. Do not let your heart become so hardened that you have no room for flowers, sunsets, smiling children. It would be the same if you lost your sense of hope, courage and joy.

"My daughter and I . . . both of us raised on Clapp's!"

"25 years ago, when I was a baby," says Mrs. William Hesketh, of Rochester, N. Y., "my parents were neighbors of the Harold H. Clapps.

"So when Mr. Clapp started making the first baby foods, I was one of the first to eat them. And my family tells me I did wonderfully well on them, too!

"Now I have a daughter of my own . . .

"My daughter, Ann, is almost three years old. She was fed Clapp's from her first mouthful of solid food. And I couldn't have hoped for a healthier baby, even though she weighed only 5 lbs. 1 oz. when she was born.

"When she was 2 months old the doctor put her on Clapp's. And at 3 months she weighed 11 lbs. 8 oz.! So even though I ***knew*** how good Clapp's foods were, I couldn't help being thrilled at what they did for Ann!

"Now she's quite a grown-up little girl. She weighs almost 35 pounds. And lively? Why, she's got so much energy that half the time I just can't keep up with her!

"She's never been a 'fussy-eater.' All along, she's loved her Clapp's foods—and spinach is one of her favorites. We spent last summer in Florida, to be near her father's Army Post. And even when the thermometer was way over 100°, Ann never lost her appetite!

"Of course, I've always heard lots about Clapp's from *my* mother. And when I look at Ann, it's awfully easy to see why doctors recommend these baby foods so enthusiastically! It seems as if a baby just can't ***help*** but thrive on Clapp's!"

Why your baby will thrive on Clapp's!

- Ever since Clapp's ***originated*** baby foods 25 years ago, we've made all our foods to fill doctors' requirements.
- We've constantly improved formulas, added foods, according to doctors' suggestions. Now we offer ***"the world's largest baby menu."***
- We make every test we can, because we ***want*** to.
- We discard many fruits and vegetables that would be acceptable for adults, but not, in our judgment, for Clapp-fed babies.
- All our foods are ***pressure-cooked*** —to help retain vitamins and minerals, fresh color and flavor.
- We have seen two generations raised on Clapp's. Our business, we believe, is the most important business in the world. It is our ***sole*** business, not a side line.
- Perhaps this is why so many doctors prescribe Clapp's regularly.

PRODUCTS OF AMERICAN HOME FOODS, INC.

CLAPP'S BABY FOODS

25 YEARS OF THRIVING BABIES!

12. Try it. It will rejuvenate and endear you to the children.

13. You will make your child feel 100 years older if you do not share his feeling of ecstasy when he sees a multi-colored sea shell, a bird's nest, or a rainbow!

14. Go out of your way to praise something on your child's school report. Nothing makes a child sprout more than a mother's praise and affection.

15. Get that facial! You will return to your household tasks with renewed energy and poise, and the children will adore you for it.

16. "Put on your old gray bonnet, with the blue ribbon on it," and take a trip somewhere, although it is no further than your neighbor's house! You will feel that you have made a long journey of discovery, even though you return convinced "there's no place like home."

17. Time doesn't fly—we fly. "He who rests rusts." Find a new hobby—it is never too late to plan something and feel young once more. Plant some seeds in the garden, interest yourself in your child's extracurricular activities, learn what the young generation is thinking about—remain young with them!

18. Spring is the time of rebirth. When the sap starts to run in the trees there should be a kindred spirit in your heart. Do not accept the change of seasons in a matter-of-fact way—retain a feeling of wonder, beauty and growth.

19. If you are continually referring to the good old days you are living in the past. About face—and look toward the future.

20. If your days are tinged with regrets and dissatisfaction with the present and you remember the years with a feeling of nostalgia, your children will sense it, and will think of you as a stranger. Look forward to the future, and the promise of the years—the best are yet to come.

Obesity

(Continued from page 111)

The physician acquainted with the factors causing disturbances in body weight regulation should decide the course and methods to be followed in an individual case. Once the course has been decided on, strict discipline in eating habits and knowledge of food values become conditions without which no results can be obtained.

In summary, obese individuals have a definite disturbance of weight regulatory mechanism, involving more than one factor, the most important of which is the caloric balance. Recognizing this fact and subjecting themselves to well-disciplined management to secure lasting results is the answer to the problem.

Baby's Safety Depends upon YOU!

PAT. NO. 2161658

BABEE-TENDA Safety Chair

Protects YOUR BABY from SERIOUS FALLS!

Baby comes into the world helpless and its SAFETY depends entirely upon you. It is this protective instinct that has prompted thousands upon thousands of parents to put Baby in a BABEE-TENDA Safety Chair. It is low and cannot be tipped or pushed over causing serious or fatal accidents. The BABEE-TENDA Safety Chair is 22" high by 25" square — is a finely finished piece of furniture that looks well in any room. It is a quality product that is sturdily constructed to give years of service, yet light enough to easily roll from room to room. A Safety Halter Strap positively prevents Baby from climbing out and mother can go about her work without fear of Baby's safety. The BABEE-TENDA Safety Chair is very highly recommended by Baby Specialists, Hospitals and Nurses. Doctors insist upon it for Baby's safety.

Copyright 1944 by The Babee-Tenda Corp'n

Some of BABEE-TENDA advantages over high chairs

NOT SOLD IN STORES

SOLD ONLY DIRECT TO YOU . . . THROUGH AUTHORIZED AGENTS. WRITE FOR FREE INSTRUCTIVE FOLDERS AND NAME OF NEAREST AGENT

THE BABEE-TENDA CORPORATION
750 Prospect Ave., Dept HM Cleveland 15, Ohio

QUESTIONS AND ANSWERS

Ice Skating

To the Editor:—Could you please inform me about what one should do in the form of training or exercise to prepare the feet and especially the ankles for ice skating?

Do you recommend the use of ankle straps or supports (worn inside the skate shoe).

New York.

Answer.—There is no set of exercises which will prepare the feet and ankles for ice skating.

Normally a person rapidly acquires the ability to balance on skates. If the ankles are weak and the person desires to ice skate, then braces are helpful. The best are those which attach to the skate and come up outside the shoe.

Physician and Patient

To the Editor:—Are physicians required to give the patient exact statements on cancer and other serious stomach and gallbladder diseases, when patient demands same or is it permissible to withhold facts? Also advise if this is true in consultations. Ohio.

Answer.—Physicians do not withhold important facts from patients when serious ailments are present. In some instances, however, a physician may feel that blunt presentation of all facts will have a serious effect on the patient's morale, and he withholds these facts in order to sustain the patient's will to recover.

Sometimes patients go to a doctor with the convicion that they are suffering from a serious disease when, in reality, no such condition exists. When the physician, after an examination, concludes that no disease is present and so informs the patient, the latter may unjustly conclude that information is being withheld.

Parkinson's Disease

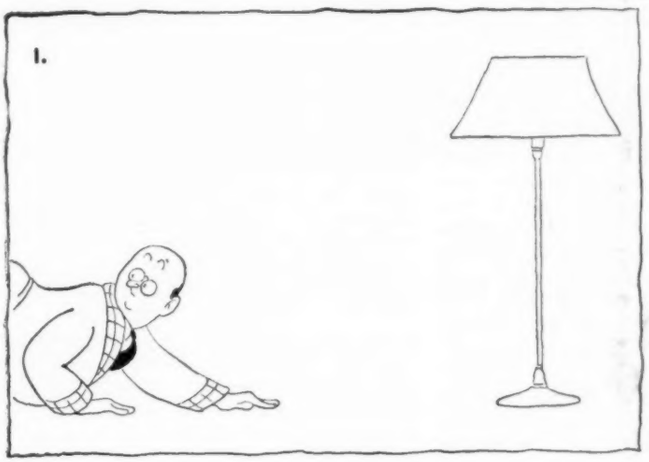
To the Editor:—Can you tell me about the latest treatment for one who has Parkinson's disease? I have heard there has been an operation on the brain for one who has had this disease. Ohio.

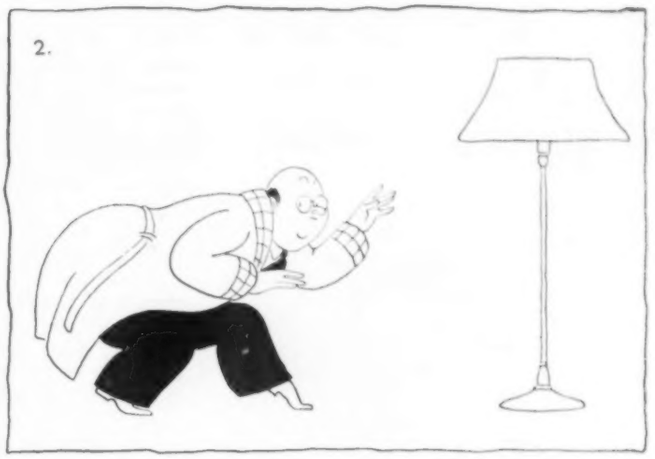
Answer.—Reports have been made recently of operations on the brain for treatment of Parkinson's disease. In the operation, part of the cerebral cortex is removed. There also has been an occasional report of operation on the spinal cord.

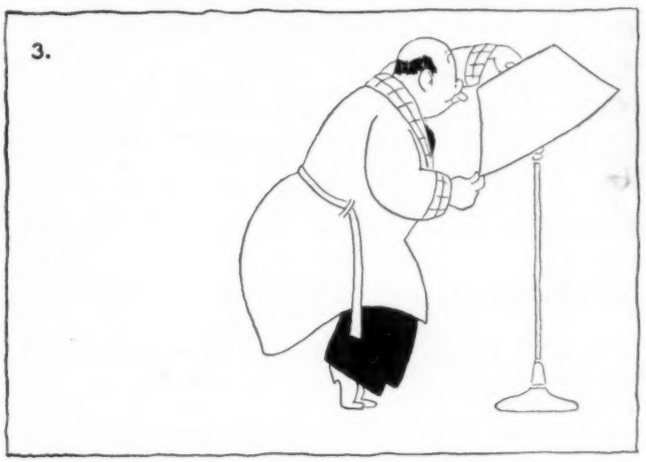
This work must still be regarded as experimental. After the operation on the brain, a certain amount of paralysis of the arms and legs has been found to occur.

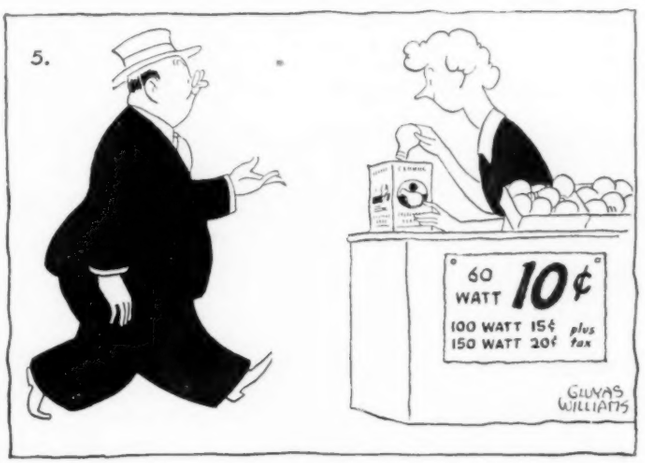
In any event, the disease itself is not cured. The only thing that is checked is the trembling of the hands, the peculiar gait and the nodding of the head.

Bulbsnatcher Story without Words . . .



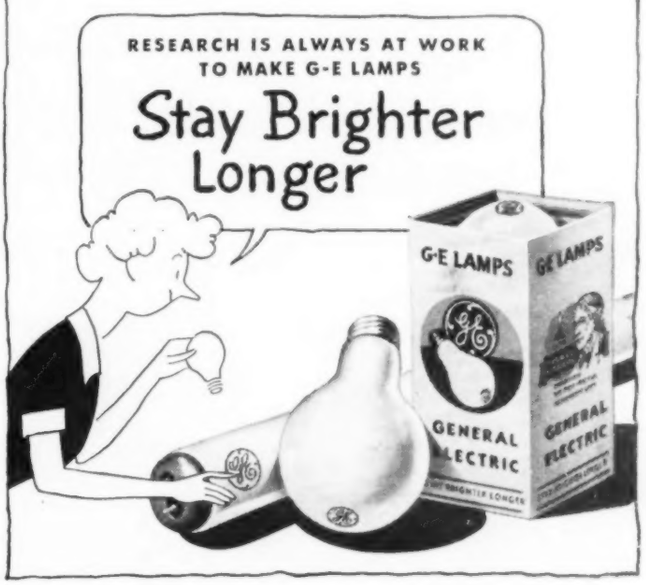






6

MORAL: Don't be a bulbsnatcher. Why make yourself unpopular and risk eyestrain when G-E Lamps cost as little as 10¢. Get a stock of extra bulbs . . . and make sure they're all marked G-E!

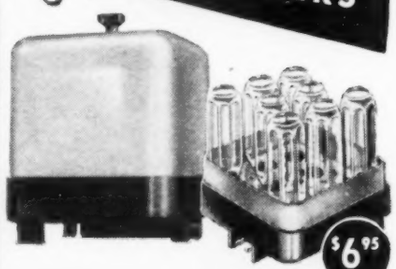


G-E LAMPS

GENERAL ELECTRIC

HOW to WIN the Battle of the Bottles!

Electresteem
8 BABY-BOTTLE STERILIZERS



$6.95

SPACIOUS 8-BOTTLE CAPACITY

Sterilizes all bottles—including orange juice and water bottle—for full day's feeding . . . at one time! Also sterilizes nipples, bottle caps, without fear of scorching.

EASIEST TO KEEP CLEAN

Finest quality aluminum top and black plastic base can both be washed with the dishes . . . without any danger to the heating element. Positively sanitary!

"LONGLIFE" HEATING ELEMENT

Patented heating element automatically shuts off when water is evaporated. No wires to break, burn or short circuit. Cannot over-heat. Durable construction throughout.

ANOTHER FAVORITE OF THE BIB-AND-BOTTLE CROWD

Electresteem
ELECTRIC SERVANT

WARMS baby's bottles
BOILS egg or potato
HEATS baby's food
VAPORIZES for colds

Easy-to-clean porcelain unit with patented "Longlife" heating element and safe, automatic shut-off when water evaporates.

$2.25 plus tax

ELECTRIC STEAM RADIATOR CORP.
Detroit 8, Michigan
Makers of Electresteem Portable Steam Radiators

My Operation—and Yours

(Continued from page 109)

addition to the routine check-up of pulse, temperature, blood pressure, blood, and urine, a surgical case is often given further tests: a basal metabolism, to make sure the thyroid gland is working properly; and an electrocardiogram, which is a check on the heart action. These tests are neither difficult, painful, nor unpleasant. A basal metabolism is extremely simple. A rubber mouthpiece is fitted between lips and gums, a "clothespin" is placed over your nose, and for seven or fourteen minutes you lie on a bed, completely relaxed, and breathe pure oxygen through your mouth. An electrocardiogram is even simpler, for you merely lie on a bed, relaxed, while the operator attaches metal plates to your arms and ankles. These are connected to a delicate machine which records the heart action on a graph.

Depending on your ailment, other tests are sometimes given. Three or four days spent in making tests before an operation may save you that many weeks in the hospital afterward, because these tests give the surgeon a clearer picture of your condition. By making sure that you are a good surgical risk, they also help to insure the safety of your operation.

About 7:30 on my big day, I was given a rectal injection of an anesthetic and within three minutes I was sound asleep, still in my own bed. About 3 p. m. I came to, feeling slightly weak, but not uncomfortable and certainly not nauseated. For a few moments I could hardly realize that the dreaded surgery was all over and here I was, safe in bed, feeling no pain and without a care in the world! The operation had been performed between 8 and 10 a. m., and I had not only been spared that horrible ordeal of the "last mile," but also the sight of the operating room with its attendant psychological hazards. If it had been a trick of magic, done with mirrors, I could not have been more astounded.

By diligent questioning, I got the whole story from the doctor and the nurses. While in that blessed sleep produced by the rectal anesthetic (which, I understand, must be used with discretion), I had been lifted onto the cart, taken to the operating room, my arms and legs strapped down, and my abdomen painted with an antiseptic. When all was ready, I was given an inhalation anesthetic of ethylene gas, mixed with proper amounts of life-giving pure oxygen. (The rectal anesthetic was not powerful enough to keep one asleep through an operation.)

Before the operation was begun, two important gadgets were put in place. An "airway" was placed in my mouth to make sure there would be no tongue swallowing (which occasionally happened in the olden days), and a blood pressure cuff was placed on my arm. Every five minutes throughout the operation, the anesthetist reported the blood pressure to the surgeon. To prevent its dropping too low, I was given 250 cc. (approximately half a pint) of blood plasma. This is another of today's preventive measures, and not only lessens the shock to the system but gives the body a head start in the process of building up. The wide use of plasma in war surgery, with a resultant low mortality, has greatly increased its present-day use in civilian life. Many hospitals even have their own blood banks, kept supplied through volunteer donors, who are much easier to get since the Red Cross campaign has shown the public that a healthy individual can give a pint of blood without hazard.

When the surgery was over and all the spare parts had been removed, the lower layers of muscle were sewed together with catgut—the smaller, more readily absorbent type—and the skin was fastened together with clips of stainless steel.

After I was back in my room, the intern rigged up a quart bottle of glucose solution (water and sugar) so that it drained through a long tube and entered a vein of my left arm, one drop at a time. Fortunately, my doctor had explained this in advance, saying that it was a routine procedure to prevent discomfort and weakness from dehydration. Hence when I first opened my eyes and saw the complicated apparatus beside the bed, with a tube leading to the hypodermic needle stuck in my vein, I wasn't at all alarmed. (One of my ward-mates later told me, however, that when she saw it she thought I was dying, and she began to cry!) To me, it was reassuring to realize how modern surgery is concerned with the comfort as well as the safety of the patient. Having had nothing to eat or drink for twelve hours and having lost fluid through perspiration and bleeding, one is bound to feel weak and parched. A gradual intake of glucose solution by vein—two quarts the first day and two quarts the second—not only relieves the discomfort of dehydration but gives a welcome strength until one can take more substantial nourishment.

Occasional hypos throughout the first two days and nights kept me from feeling any pain whatsoever, while on the third day this same happy result was obtained by a few pills. After that, there was no necessity for either. One of the worst bugaboos of all operations is the dread of gas pains. Abdominal surgery may leave the intestine in a static condition, and when gas forms it cannot escape naturally because of the inactive state of the bowel. The insertion of a rectal tube allows the

Meat Goes a Long Way in Assuring Protein Nutrition

The nutritional needs of the human body are many and varied. Only in recent years has come a full realization of the complexity of these needs and their significance in promoting optimal growth, buoyant health, and resistance to certain infectious diseases.

While in years past the caloric value of the daily dietary was regarded as being of primary significance, today nutritionists know that other factors are equally important. Satisfaction of protein needs now is regarded as one of the principal requisites of the well-balanced dietary. When an insufficient amount of protein food is eaten, normal growth is impossible, proper maintenance of tissues cannot take place, strength lags, and resistance to infectious disease may drop.

Meat ranks high among foods as a source of protein. Containing all the amino acids considered essential to life, it goes a long way in assuring good protein nutrition. One or two servings of meat a day provide a large proportion of the daily protein needs. In addition, the complete protein of meat enhances the value to the body of less complete proteins obtained from other sources. All meat is a good source of high quality protein, regardless of cut or method of preparation. And meat also provides significant amounts of iron and B-complex vitamins.

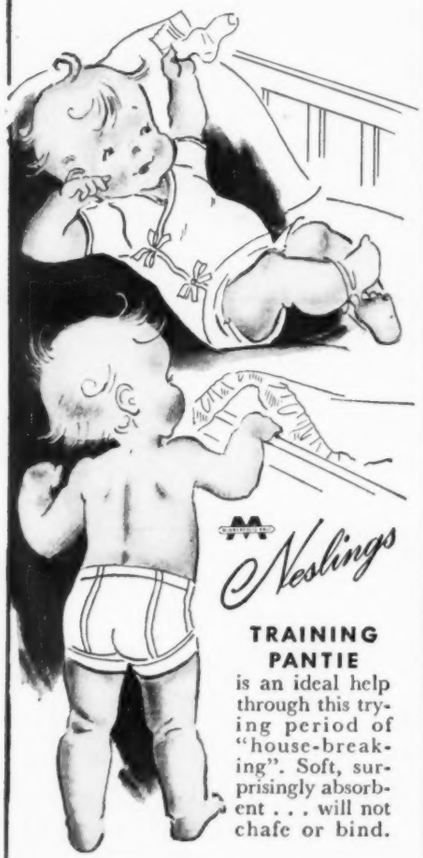
The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

AMERICAN MEAT INSTITUTE

MAIN OFFICE, CHICAGO . . . MEMBERS THROUGHOUT THE UNITED STATES

THE LABEL MOTHERS KNOW AND TRUST

Look for this label first, because it means all the things that smart mothers are looking for in baby garments. Soft, fluffy, non-irritating . . . "M" Neslings baby shirts are knitted of finest yarns . . . save mother so much time and energy, because they're so sudsable and durable, and give baby such *happy comfort* and daintiness.



Neslings

TRAINING PANTIE is an ideal help through this trying period of "house-breaking". Soft, surprisingly absorbent . . . will not chafe or bind.

And "M" Neslings *night pantie* means greater comfort for sleeping toddlers.

REFUND OR REPLACEMENT GUARANTEED BY PARENTS' MAGAZINE IF NOT AS ADVERTISED THEREIN

Minneapolis Knitting Works

Minneapolis 11, Minnesota

gas to escape and frequently ends the discomfort at once. At least it did for me; some cases might prove more difficult to relieve.

When sufficiently conscious to inspect myself, I found that I was all bound round with a wide adhesive girdle that laced in front and held in place several thick layers of dressings. Such a girdle has many advantages over the old-fashioned binder or bandage, and it provides the utmost in protection, comfort, and convenience. To examine the wound the surgeon merely unlaced the girdle and lifted up the dressings. There was none of that painful ripping off of adhesive.

It is natural to have a slight rise of temperature for three or four days; that is the body's way of meeting the strain put upon it. You can also expect some difficulty in going to sleep at night (especially if you're not used to sleeping on your back), but this is readily overcome by the mild sedative that is given at bedtime. The only other medication I had was an assortment of vitamins and iron pills. Orange juice, served as a part of the hospital diet two hours after every meal, might also be considered as a healing agent as it is rich in vitamin C.

There are two things to be avoided during the first week after surgery: coughing and kissing. Quite obviously, coughing causes pain and may even prevent the healing of the wound. If you feel a cough coming on; take a few sips of water; that will usually stop it. Kissing is out, not because it's strenuous but because of the risk of catching a cold or some other infection. Incidentally, infections resulting from the surgery itself are practically nil nowadays, thanks to strict aseptic technic and the wonder drugs sulfa and penicillin. If the operation is of the type in which there might be contamination, either sulfa or penicillin is administered until the danger period is over.

On the fifth day, the doctor removed about half of the twenty-one clips that closed the incision, and loosened the others. They looked much like staples, except for the sharp points at each end. There was scarcely a pin prick of pain when the first ones were taken out, and no feeling at all when the others (previously loosened) were removed. If the surgeon uses reasonable care, there should be no pain in removing either stitches (thread) or clips. The much talked about torture of taking out the stitches is merely another bugaboo of surgery that has come down through the years. Adhesions, too, may be largely prevented by the newest operative technics. While I have described in detail the materials used and the procedures followed in my own case, particularly as regards preoperative anesthesia, adhesive girdle, and clips, this does not imply that these are the only methods used by skilled surgeons. Variations in these technics are sometimes necessary to meet the needs of the individual patient.

At present there are two schools of thought on the matter of sitting up and getting out of bed. One group holds that the earlier the better, in order to stimulate circulation and prevent muscle weakness. These surgeons allow patients to sit up on the second or third day and get out of bed on the fourth. The other group, however, believes that complete rest is the best policy for the first week after an abdominal operation. In the final analysis, of course, much depends on the type and seriousness of the operation, as well as the recuperative powers of the patient. Since my own surgeon belonged to the more conservative group, I wasn't out of bed until the eighth postoperative day. At that time, however, I was able to walk in a normal manner—no bending over to protect my wound—and I felt no dizziness or undue weakness. From that time on, I gained strength rapidly, increasing my activities every day. On the fifteenth day I went home—walked home, in fact.

For the first two weeks I felt completely lazy, content to do very little. When I was well into the third week at home and my usual energy and ambition had not returned, I began to worry. But here again, worry was needless. Suddenly, at the end of the third week, all my former pep returned. It was really thrilling to feel the sudden rush of energy and radiant health. The period of convalescence was over, and nature was giving me the green light. So don't be alarmed by the lethargy that lasts from two to four weeks after you are up and about; it is merely nature's way of putting on the brakes, of slowing you down until you are fully ready to lead a normally active life again. Until this time arrives, it's foolish to force yourself, or to be "smart" and show how much you can do. Six weeks after the operation (or approximately four weeks after you go home), you should be able to do anything. Don't be alarmed, either, if you are emotionally off-center for a few weeks. Crying spells or outbursts of temper, for no apparent reason, are a natural result of certain types of surgery. When you are physically back to normal, your emotional poise will also return.

The by-products of a hospital experience are almost as valuable as the surgery itself. First of all, you get two weeks complete rest, both physical and mental, and where else except in a hospital can you get this welcome experience? Every organ of the body benefits, but especially the heart, which takes a new lease on life. If your blood pressure has a tendency to skyrocket, the rest will bring it down to a more normal level. Even your skin gets a "breather," and is all the better for the absence

OBSERVE THESE "SAFETY FIRSTS" OF BABY CARE

By Meredith Moulton Redhead, Ph. B.
Baby Food Counselor of Heinz Home Institute

PROTECTING baby against the possibilities of a home accident is largely a question of observing a few basic safety rules which are sometimes forgotten in the hurry and hustle of the day's routine.

First, never leave baby alone even for a moment on an unguarded surface or in the bathtub.

Second, avoid burns by checking the temperature of the water with a bath thermometer before placing baby in the tub.

Third, prevent suffocation by tucking the undersheets on baby's bed firmly beneath the mattress, eliminating pillows and allowing him to sleep alone.

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Question Box on Baby Feeding

By Meredith Moulton Redhead, Ph. B.
Baby Food Counselor of Heinz Home Institute

1 QUESTION: How should egg yolk be prepared for baby?

ANSWER: It is equally satisfactory to prepare the egg yolk soft or hard-cooked, poached or coddled. And you can serve it by itself or mixed with baby's strained vegetable or cereal feeding. And to get additional quantities of this important protein food into baby's diet, why don't you serve Heinz Strained Custard Pudding? It's a smooth, delicious, creamy pudding that your baby will really enjoy.

2 QUESTION: What might cause a baby to sleep poorly?

ANSWER: Many factors can contribute to this condition. For instance, you may be using too many or too few covers on baby's bed. Perhaps there isn't sufficient fresh air, or the sleeping room is too hot or too cold. In fact, the wrong diet may be the root of the trouble. Not giving baby enough of the proper kind of food would make him fretful. However, when you serve him Heinz Strained Foods, you can be sure of plenty of variety—and nourishment. For all Heinz Strained Foods are scientifically cooked and vacuum-packed to preserve a high degree of vitamins and minerals.

3 QUESTION: Should a mother be concerned if her baby isn't making regular gains in weight?

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of cosmetics for a few days—to say nothing of the absence of lines that are smoothed out by complete relaxation. Two weeks' rest in a hospital is equivalent to a whole course of beauty treatments—with the proper diet thrown in! If you are overweight, an operation is bound to take off a few unneeded pounds. Don't overlook these advantages when you plan some time off for surgery!

A less tangible but greatly appreciated by-product was "time on my hands"—time to catch up on reading and letter-writing, but above all, time to think, to take stock of things, to make some new evaluations, to meditate on life in general. A hospital experience also gives an unequaled opportunity to find out who are your real friends—although at the risk of occasional disillusionment!

Surgery has been surrounded with a number of bugaboos that need to be exorcised once and for all. Any operation today can be safe and practically painless (as mine quite literally was) provided (1) you have a good surgeon and (2) you are in good physical condition. Modern preventive technics and skilled surgery will do the rest. Of course there's no denying the fact that you do take a minimum of risk—but what about the chance you take when you board a plane, go for a swim, take a boat ride, drive a car, travel by streamliner, or cross a busy city street? Or even when you enter a skyscraper elevator! Readers too young to remember the Titanic will readily recall the plane that crashed into the Empire State building! No, you take a far smaller chance in the hands of a capable surgeon than you do every day in the ordinary routine of your home and business life. It is a known fact that more accidents occur in the bathroom than in the operating room.

• • • •

The actual operation described in this article is step number two in the prevention of the most common type of cancer in women—cancer of the uterus. The first step is a thorough physical examination at regular intervals, as described in "An Ounce of Prevention: Today's Cure for Cancer," HYGEIA, October 1944.

Perhaps, like me, you have always been a normal, healthy person, with no evidence of any pathological condition and no premonition of impending surgery. You have gone regularly for a thorough checkup, and every time the doctor has pronounced you fit and healthy. Every time until the last time, when, with a sense of shock almost past belief, I heard the words, "You need an operation." The doctor went on to explain that growths, or tumors, had developed in the uterus, and in order to prevent future trouble it would be wise to remove them.

"What would happen if they are not removed?" I asked, shying away from the thought of surgery.

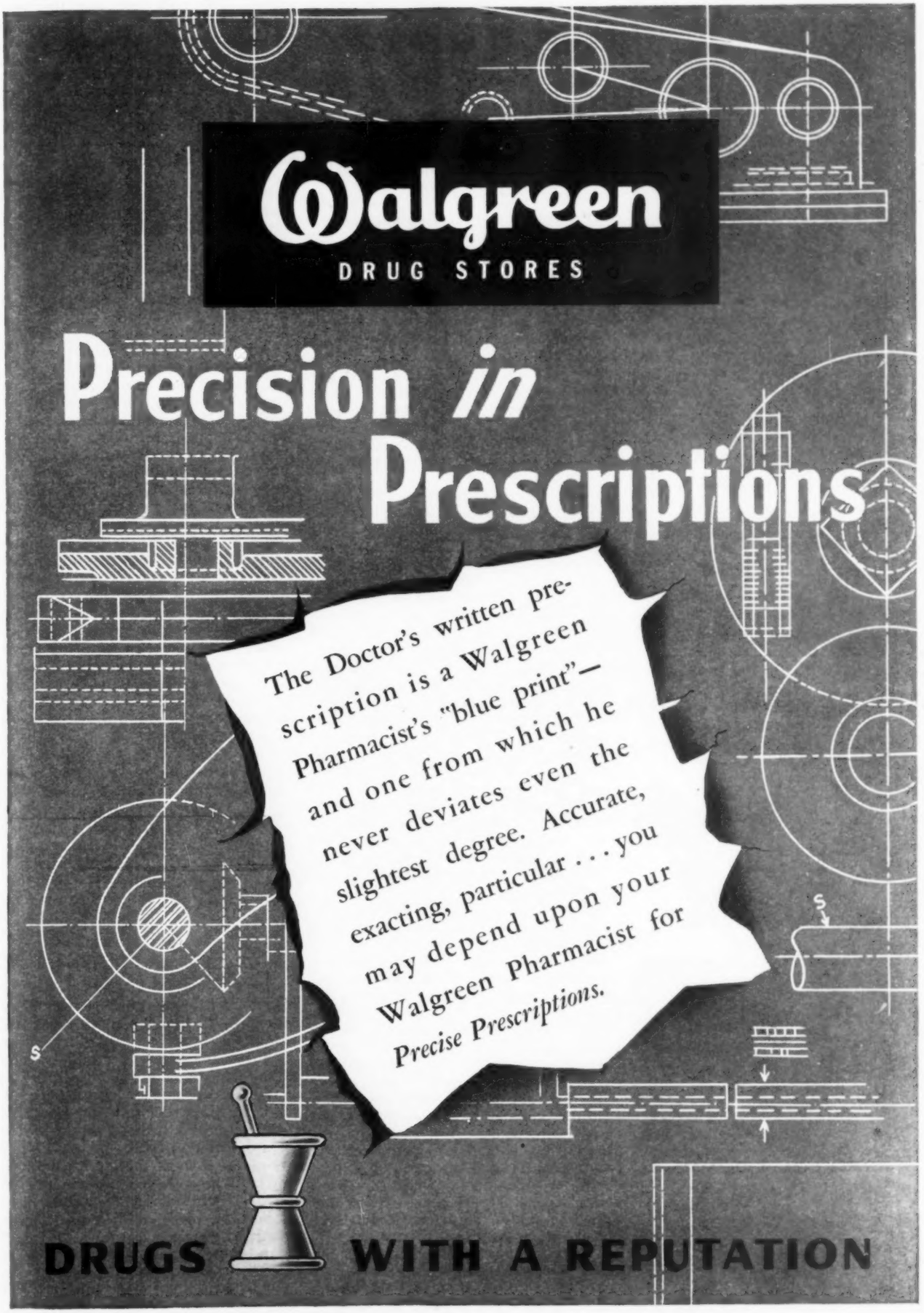
"It is possible, of course, that nothing will happen," said the doctor with matter-of-fact honesty. "But it is highly probable that you will have profuse bleeding during menstruation, or severe pain and fever. In many cases, a tumor will prevent childbearing. Sometimes a tumor becomes strangulated, with the possibility of gangrene, and an emergency operation is necessary. A tumor may be the forerunner of cancer, but it is impossible to tell whether it is benign (harmless) or malignant (cancerous) without removing the tumor and studying it under the microscope."

There was my answer: sterility, gangrene, cancer. Not a pleasing picture, is it? Not one of the three was a certainty, but on the other hand, there was no guarantee that any one—or all three—might not take place. The doctor went on to say that at a conservative estimate, one woman in every five develops tumors of the uterus. Among female deaths in the age group 35 to 65, statistics show that one woman out of every five dies of cancer, and 30 per cent of these cancers are in the genital organs. Faced with these facts, I did some serious thinking. It didn't take me long to make up my mind, and within a short time from the time I heard the pronouncement, "You need an operation," the indicated surgery had been performed.

The surgeon removed one tumor the size of an orange and several others the size of walnuts. A microscopic examination of the tissues showed that none of these tumors were malignant, but there is no telling what proportions they would have reached or what symptoms they would have caused if the operation had been delayed indefinitely. After all, they had reached this size in less than six months! To date, the medical profession has not discovered what causes a tumor to develop or what factors contribute to its growth. There is no known method of preventing them or of checking their growth. Until further facts are discovered, surgery is the most satisfactory way of handling tumors and preventing their disastrous consequences.

"Female" surgery has come an unbelievably long way since that fateful day in December 1809, when Dr. Ephraim McDowell, of Danville, Kentucky, performed the first ovariotomy known to medicine. If you hesitate at the thought of an operation, think for a moment of what the courageous Jane Todd Crawford went through—the removal of an ovarian tumor weighing 22½ pounds—and all without benefit of any anesthetic or any aseptic technic! Yet she recovered and lived to the ripe age of 78—thirty-two years after her history-making operation.

See your doctor regularly, and when he (or she) says, "You need an operation"—go ahead and have it—safely and painlessly. Above all, don't delay—and don't worry!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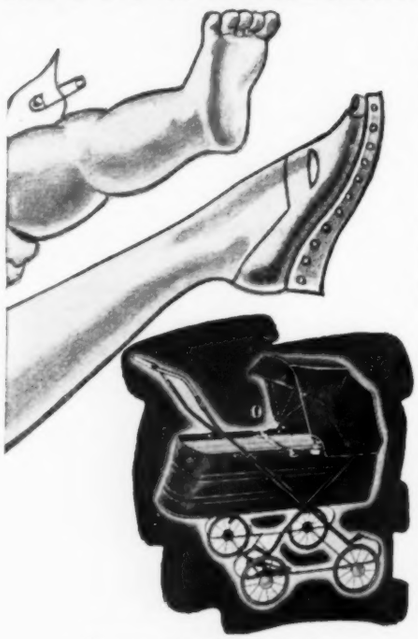

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Suffer Little Children

(Continued from page 95)

else in this world. The only sure relief comes when a second normal child is born. As you watch this baby develop and feel it responding to you in a way that was not possible for the first child, then you will thank God that you had the courage to part with the deficient child, going against every instinct you possessed.

When you first give your child up, a tremendous feeling of guilt will possess you. You will want to hide from friends and relatives, because you will know that they cannot possibly understand what you are feeling. This can be fatal and you must avoid it at all costs. We tried to run away at first, avoiding friends and avoiding the subject of our baby. The real danger in this is that you are treating your misfortune as something shameful, when it is entirely something different from that. However, if you persist in this attitude, it will become shameful to you and to your friends.

We had a large circle of friends, most of them with children. We had taken great pride in our baby and in "showing her off." Later, after the tragedy, we couldn't be normal with these people. When they called, we could feel their interest in our problem, but interpreted it as morbid curiosity. We avoided the real issue between us, making all present uncomfortable. Later, after we had gained insight into what was happening, we deliberately brought the baby into our conversation, talking quietly and normally about her condition, neither asking nor expecting pity. The effect on our friends was amazing. They suddenly found themselves at ease with us and we with them. Their friendship was again comforting and sustaining. Rather than blaming us for our actions, we found that they respected and admired us for our courage.

To friends of such parents, we suggest the following line of action. Wait for at least a week after they've given up their child before calling. Make your visit short and unemotional. Assure them of your loyalty and understanding, but do not express pity. If such parents are at first hesitant to resume normal social relations, be tactful, but demonstrate your friendship regularly and, above all, don't avoid the subject of their child. Talk of it just as you would any other sick child, because they love it just as dearly as you love your own children. You can be a real force in speeding their recovery and, later, your friendship will be valued far beyond anything it could have been before the tragedy.

We have written this article at the risk of alarming many who are parents of children slow in developing. The chances are several hundred to one that your child is normal, but slow. However, if there is the slightest doubt in your mind, you should consult a reputable pediatrician at once. He will tell you the truth. Many children are slow and dull because of pathological disturbances or glandular deficiencies. These children very definitely can be helped, if caught in time, by surgery and synthetic glandular extracts.

Most large cities maintain free children's clinics, which are available to parents even in the lowest income brackets. We would advise, when possible, that all babies be taken for monthly check-ups. If your child is deficient, the sooner you learn the truth the less painful it will be for you in the long run. If you prefer a private pediatrician, his fees are quite moderate; many range from $2 to $5 per month, and you are free to consult him at any time.

My wife was attended by a prominent obstetrician throughout her pregnancy and the baby was delivered normally. A few weeks after her birth, however, my work took me to a small country city, where there was only one doctor. He gave the baby her shots, but did not recognize any deficiency until we became alarmed at her lack of progress and called it to his attention several months later. A doctor trained in the treatment of children might have caught it immediately and saved us months of worry and false hope.

Since suffering our tragedy, we have become increasingly conscious of the same problem faced by others. Our present baby is being attended by a pediatrician who has a large practice. He has told us of many similar cases which have come to him. There are charlatans and religious quacks willing to offer hope to those unfortunate parents who, like drowning men, grasp at straws. After taking exorbitant fees for months or years, and reporting progress which is physically impossible, the parents finally consult a reputable physician and then must make the final decision—a decision which becomes more difficult to make with each passing day that the child remains in their home.

We can look back on our own tragedy now without shame or regret, knowing that we did the only sensible thing possible. There have been compensations to offset our sorrow, although the scars of complete heartbreak are never permanently erased.

We never see an undernourished waif in the street that our hearts do not bleed for him; and we never read of a delinquent father or mother that we do not want to tell them of the joy and happiness they are missing by destroying a normal child. More important, our marriage has become something richer and more satisfying than before our tragedy. No problem or adjustment can ever again seem insurmountable to us, and we love and cherish our other children with a wholesome passion possible only to those who have lost a child.

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Arthritis and Rheumatism

(**Continued from page 113**)

painful attacks of arthritis often coming on suddenly while the patient is in bed, involving one joint, most often the foot or toe. The affected joint is red, hot, tender and swollen, the patient has a fever and there is an increase in the white cells of the blood, all signs seeming to indicate infection which the gouty patient actually does not have. The attack, lasting days or weeks, eventually ends, leaving the patient completely well until the next attack which may be years later. While attacks may occur spontaneously, they may be induced by overeating or overdrinking, by injury or surgical operation. Repeated attacks of gout result in uric acid deposits in the joints causing bone destruction and a deforming type of degenerative joint disease. Collections of uric acid sometimes become large enough to ulcerate through the skin.

Although gout occurs in all mankind it is predominantly a disease of men. Its origin lies in the inability of the body to dispose of uric acid which is an end product of metabolism normally found in the blood and excreted in the urine. The gouty patient has an abnormally high level of uric acid in his blood whether or not he is having an attack. This level can be elevated by his eating a diet rich in purines, chemical substances producing uric acid. It is not known how acute attacks are precipitated but they are not related to changes in uric acid concentration in the blood. People with gout have abnormally high concentrations of uric acid in their blood long before they develop attacks. In fact, one fourth of the brothers and sisters of gouty people have high blood uric acids, and are potential gout patients.

Treatment of arthritis requires as much skill in the art of medicine as it does in the mastery of science. Treatment is directed at the symptoms. Stiffness, soreness and limitation of motion are complaints in rheumatoid arthritis and degenerative joint disease and can be treated alike. Aspirin and aspirin-like drugs may be used generously and continuously. Liniments applied with gentle massage may also give relief. Chloroform and oil of wintergreen liniments are frequently used.

Local heat is effective. A hot water bottle, electric pad or an electric blanket are easy to use and are helpful in lessening the pain. Although infrared lamps are cumbersome to use and are more expensive than other heat appliances, they are more effective.

Short wave diathermy, through the use of electromagnetic radiations, is an approved treatment for degenerative joint disease and helps rheumatoid arthritis. Other forms of physical therapy, whirlpool baths, paraffin packs, underwater exercise and galvanic stimulations are also useful.

Artificial fever therapy is effective in the treatment of rheumatoid arthritis. It produces a general relaxation and opens small blood vessels resulting in better circulation to the entire body, especially to the hands and feet. The most beneficial effect, however, is relief of muscle soreness, decrease of joint stiffness and decrease of pain. This effect lasts only several days to a week but may be very important in gaining rest and relaxation for the patient. Treatments are given at intervals of one to two weeks and continued as long as the patient feels relieved.

General health care is important in the treatment of rheumatoid arthritis. The diet should contain protein, minerals and vitamins with sufficient calories to replace lost weight. This demands milk, meat and eggs, whole grain wheat or oat cereal, and fresh fruits and vegetables daily. Iron, added vitamins or liver extracts are indicated for anemia. Repeated small whole blood transfusions may be helpful for run down and exhausted patients.

A frequent question is, "What kind of shots do you generally give for rheumatism, doctor?" While these include intravenous salicylates and iodides the popular treatment consists of injections of gold salts, although its effectiveness is questioned.

Some immunize the patient against streptococcus or other organisms. Others desensitize him against a bacterial protein and a third produces a protein shock effect.

Arthritis usually carries with it a most unhappy association. Despite enlightened medical and scientific care, the advanced case of arthritis is a pathetic sight.

To illustrate, the author analyzed the last 200 patients who consulted him for rheumatism. Many had been told they had arthritis and that there was no cure for it. A few had followed tedious, expensive, ineffective and unnecessary treatment.

Among these 200 patients, 42 believed they didn't have arthritis. Eleven patients in the next group had what is termed conversion neurosis. This meant their backaches and leg aches were the physical expression of an emotional problem. They are the nervous patients who give doctors "organ recitals." These patients are readily recognized, for as soon as one complaint is disposed of they discover a new, perhaps imaginary, ailment.

The next 23 patients complained of tender joints and stiff muscles. The joints seemed normal but the muscles were tender to pressure. Some of them had menopausal symptoms, others had secondary anemia. All improved on vitamin B complex, iron and ovarian replacement therapy. None developed deforming or disabling joint disease.

Eleven patients had symptoms due to postural defects such as flat feet or excessive curvature of the spine. The final group of 19 patients had other diseases associated with pain or stiffness but these conditions were not related to arthritis. Of the original group of 200 patients, 106 did not have arthritis. Most of them, however, had mild, self-limited disabilities.

But 94 of the 200 patients did have true arthritis. Twenty-eight had rheumatoid arthritis, 10 had spondylitis, 22 had degenerative joint disease, 6 were afflicted with Heberden's nodes and 5 had spondylosis. Nine other patients had disease of the joints, each with a rare but unimportant condition.

A 1937 National Health Survey taken by the United States Public Health Service found rheumatism the most prevalent of chronic diseases. It was estimated that there were 6,850,000 persons disabled with rheumatism, and of this group approximately half of them had arthritis. On the day the survey was computed, it was found that the total compared to approximately half the number each of cases of chronic heart disease and high blood pressure.

Rheumatism caused the loss of 97,200,000 work days in one year—it was also the second most important cause of chronic invalidism, accounting for 147,600 victims being absent from work for a year or more.

A 1929 health survey in Massachusetts revealed that rheumatic disorders were the common cause of chronic illness in patients over 40 years of age. The survey stated, "Rheumatism cripples in the largest number of cases and kills in the smallest. This ability to cripple without killing would seem to put it in the lead of all other chronic diseases as of preeminent social, economic and medical importance." Similar conditions have been reported from surveys made in Connecticut, the British Isles, Scandinavia and other countries in Continental Europe.

Why is there such mystery about the rheumatic diseases and why has therapy been so ineffective? There are many causes for the present state of affairs. First, chronic rheumatism has long been the stepchild of medicine. There is nothing dramatic about it! It begins almost unnoticed and the patient gradually develops his disability to the point of wheel chair or bedridden helplessness.

Variations in severity and diversity of involvement produced by two types of chronic arthritis are imitated by similar clinical pictures presented by other conditions. These include lumbago, sciatica, disk syndrome, postural defects, gout, scleroderma, trophic bone disease, stiffness and soreness of the menopause and other ailments. Critical evaluation of the treatment is difficult. Arthritis characteristics such as joint pain, muscle soreness and stiffness, change rapidly. These fluctuations make it impossible to measure the effect of drugs or manipulation. In pneumonia the temperature falls promptly in response to sulfa drugs or penicillin; in diabetes the blood sugar always falls when insulin is given and in pernicious anemia the percentage of reticulocytes in the blood invariably increases with liver extract. Such cases demonstrate that therapeutic measures have been effective. We have not yet discovered similar guides to test the treatment of arthritis.

The problems of arthritis are not unsolvable. Little progress has been made because, frankly speaking, we have been disinterested and neglectful. Figures have been compiled showing that in 1940 various foundations appropriated for the study of cancer the equivalent of $2 for every death from that disease, $4 for every death from infectious disease and $525 for every death from infantile paralysis. We have no figures for the appropriations for research and study of arthritis but they are pitiably small.

The causes of arthritis have not been satisfactorily identified, although numerous theories have been advanced. Perhaps the most popular one is that of infection. This theory provides that bacteria in tonsils or at the root of a dead tooth pour poisons into the blood which travels to the affected joints producing the disease. The theory has not been proven and the routine removal of teeth and tonsils, gallbladders and appendices, the draining of sinuses, the cleaning out of middle ears and of Fallopian tubes, even when diseased, have not resulted in convincing benefits.

Theories suggest that various types of toxemia, depletion, deficiency, exhaustion or emotional strain are the cause of arthritis. They leave much to be desired. When the true cause of arthritis is found, some of these possibilities may be accepted as contributing factors.

I feel confident that the wise administration of intelligent effort employing modern scientific facilities supported by individuals, corporate foundations or divisions of the government will be rewarded by successful results. As individuals, as responsible members of family groups or as citizens of the community we can no longer afford to neglect the rheumatic diseases. They are important from an economic, a social and too often a personal point of view.

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Returned Veteran

(Continued from page 99)

riage in addition to the problem of being the mainstay of his own family.

In another case, a returnee's mother had had a difficult time. She had been ill, somewhat low on funds and lonesome during his absence. She did certain things that annoyed him, when he returned, and this only increased his worry about her. He could not sleep, couldn't eat—lost weight. She, in turn, worried about him. The two of them created a circle of concern about each other.

Often too much responsibility is piled on the returnee in the first weeks, before he has had time to get back his former resilience, and before he has satisfied his need for rest.

The conflict that a normal returnee has over resuming his former ambitions and responsibilities and his previous goals of civilian life—versus the tendency to go back to adolescent irresponsibility and take things easy—is epitomized in a dream which a returnee had. He was a stable fellow, and at first he could not understand why he had this type of nightmare on his first leave at home—but actually this dream expressed the forces at work in his personality at the time.

He dreamed that he was in his home town (as he now actually was), and he was standing in front of the corner drugstore. Two army bomb trucks came along from different directions. The street was too narrow for them to pass each other, they could not stop—and there was a terrific collision and explosion. He awoke in fright.

He said he used to see bomb trucks of that sort daily, loading bombs on bombers in the Southwest Pacific. The drugstore was the one where he and his friends used to "hang out" during high school days, a period that was the happiest in his life. He was carefree then—and now he talked longingly of those irresponsible days when the boys went fishing on Sundays, and had sodas at the drugstore after school and watched the traffic, usually out-of-town trucks, going by.

Discussing the dream, he said he was tense while he was home. He did not know why. But then it became clear that a conflict had been awakened on his return home. What he really wanted was to be a young high-school boy again. It had been his plan to study law, as soon as he got back. But the idea of facing adult responsibilities had set off conflicts, and his battle fears were reawakened; he hadn't thought about these things consciously, but they had made him tense and produced the nightmare. This amount of conflict, on first homecoming, occurred in a well-rounded, balanced personality and is typical of what might be considered normal.

Besides the conflict over responsibility, a second source of difficulty for the returnee is frequently a feeling of irritability that he may have for a few weeks on his first return home. This irritability is based on a residue of the anxiety that had to be repressed constantly in combat—and is a concomitant of the period of recovery from strain. It is also the effect of the many frustrations of army life. Perhaps in your own experience, you have known the irritability that comes from working at an almost impossible task, trying to cope with all sorts of problems, in extremely hot weather—after a poor night's sleep. This irritability mounts when it goes on for years. It is known in the Army as being "browned off." It frequently is directed against the Army, because the Army is identified with the fear-provoking situations, and the frustrations. At home, the family may feel that the returnee is inclined to be irritable about "little things." The "little things" may have more significance to him than his family realizes.

For example, one returnee's recent bride was unable to cook certain breakfasts for him, and he had to scramble the eggs himself. This bothered him and she resented his making so much fuss about what seemed a trifle. For him, it was not a trifle, because he had been eating K-rations for a long time, and had had dreams of what his home-coming and married life would be like—and was now disappointed. In another instance, a returnee's family said they thought he could not have done a good job overseas or he would have been promoted. This too, evoked a reaction of intense irritability.

Families sometimes express concern because a veteran has come home quite irritable after years of Army service in some remote spot where "he was not even bombed." Men who have not seen actual combat experience strong reactions, sometimes, after spending years in the Army. This is particularly true of those who have served in isolated places, under conditions of extreme monotony and climatic harshness—Ascension Island, for example, was a place that produced a strong reaction in people who had been stationed there for seemingly endless periods, feeling unconsciously—as a lonely child feels—forgotten and rejected. Although the family may write frequently, although they realize that the war necessitates their sons and husbands being stationed in these isolated places, the men living there for years cannot help but build up certain unconscious feelings that they are not wanted. Such a man returns home with accumulated frustration. He may, for a time, reject others, or feel that they are rejecting him and really do not care about him. In that frame of mind, he needs a particularly warm and sincere welcome at

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home. If he seems unresponsive or irritable for several months, it may merely mean that he is in the process of working through his experience. His reaction of hypersensitivity should diminish in a reassuring, cordial environment. But, if he finds that his job has been given to some one else, who has advanced over him during his absence, or that his wife has become interested in another man during the years he has been away, and wants a divorce, he is going to be more deeply embittered.

A third difficulty that may arise during the transitional period of a veteran, is a feeling of restlessness—and even a feeling of isolation—because of the breaking up of his group overseas. This is particularly true in the air forces, because of the close association of men in aircrews.

For instance, gunners often speak of their pilot as having been the best pilot, or refer to other members of the crew with the same high regard. They are actually physically dependent on each other since the teamwork of the bomber crew is exceptionally important in their performance. During particularly hazardous missions members of a crew derived great emotional support from each other. Sometimes a more mature man in the crew would assume the role of leadership—often a pilot took this role, since he was actually the commanding officer on the plane. Off duty overseas, the men tended to continue these close relationships. When a member of an aircrew has finished his missions and is returned, he often feels keenly the loss of his relationship to the crew. It is difficult for him to form other associations quickly since he contrasts his attitude toward new acquaintances with his attitude toward his crewmates. Should a gunner, for example, meet one of his buddies—and these joyful greetings are a common occurrence at Redistribution Stations and separation centers—the close former companionship is resumed. After a young man goes back to college or a job his new relationships will automatically be compared with those intense wartime friendships. And his own family may also feel excluded for a time because of these attachments.

The returnees may also experience a mild form of nervousness when they first return home. In this group, earlier emotional conflicts which they have had toward their families have become reactivated because of their fatigue and because certain events in their army life have stirred up conflicts that originated at home.

The roots of emotional conflicts usually have their beginning during the early, formative years, in the home environment. Conflicts that have developed with members of the family in childhood are carried through life, and the return home often means a return to the scene where these basic conflicts originated.

Added to this, in some cases, emotional strains incurred during combat may be reactivated on coming home, in a way the returnee does not quite understand. He may feel that he should not be back at all, enjoying himself, when some of his close friends can never return, and this may burden him with a sense of guilt. These feelings of guilt, or a sense of things left undone, should be understood as a reaction frequently seen in veterans—a sense of guilt which is not based on actual fact, and which in most cases dies down in time.

Conscience reactions, also, are frequently intensified in the family scene. After war experiences there may be a feeling of heightened sympathy and pity toward those at home and guilt over expressing any annoyance.

These emotional problems should neither be exaggerated nor underestimated. The average soldier is resilient. He is youthful and venturesome, and has strong recuperative powers. He is usually quite capable of handling the types of reactions described, and these reactions tend to subside in a matter of weeks. Some returnees who have been overseas a long time, feel irritable and restless and rather tense for a longer period when they return, and then these symptoms too begin to disappear.

What are the essential factors that enable a human being to regain his equilibrium? What makes the veteran's transition period easier?

First, a man whose previous personality adjustment was good has a strong ego which can readjust itself, particularly if he has not been through war experiences that were extraordinarily severe. Second, if the family situation has remained relatively stable, he can adapt himself to it more easily. And third, in regard to his further education or his job when he gets out of the Army, he wants to feel that he will have an opportunity to make up for lost time. His fatigue, after years in the Army, tends to increase his feeling of being "too old" to go back to school, or "too old" to start the business he had wanted. This feeling of depletion may make him anxious to get started and prove his own strength; in some cases he may want to develop latent capacities he may have discovered during his wartime service. The opportunities which the community affords him will have a real effect on his emotional stability and will aid his morale as well as his financial situation.

The desire to get out of the Army and home has been strong for a long time. Sometimes it was exaggerated because of the unconscious wish to get away from anxiety-provoking situations in combat, and the desire to avoid the frustrations of army life. Until the returnee gets back to civilian

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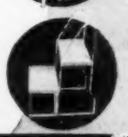

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life, a certain amount of irritability will persist. This discontent with army life is a good sign, on the whole. It is the reaction of people brought up in a democratic regime, and hostile toward infringement on personal freedom. Regimentation and an authoritarian way of life do not fit in with the returnee's personality, and his future interest in preserving democracy will be greater. What the veteran wants is democracy and peaceful goals. When he becomes a civilian he should be able to devote his energies to the current scene and to his own development.

The less frustration in everyday living, the quicker his readjustment. His basic needs for a home, for an education, for a job, for sound family relationships, will become goals that take the place of wartime aims which he had to adopt for years. The longer the delay in economic opportunity the longer the returnee's adjustment will take.

In order to master the anxiety from his war experiences, the returnee goes through a period of reality-testing. He tries out his new environment and his capacities; reestablishes friendships and revives his ambitions. He needs to regain objectivity about the civilian scene, and gradually to establish definite goals.

In the general scene, the returnee also has to be convinced by the development of peace aims that another war is not going to occur soon again, that the legislators mean business, and that he has not made sacrifices in vain. He is skeptical, not easily appeased by bombastic arguments—he wants facts.

In his transition into civilian life, the veteran's attitude toward groups of people may play a role. He may feel a need for group affiliations to take the place of army groups which during the war gave certain satisfactions to the soldier, and taught him the sense of security one gets from teamwork and esprit de corps. These groups should necessarily have constructive goals. The family as a group, too, can lend security to the veteran, rather than have a demanding or dependent attitude toward him. His employer and work associates may do a lot to assist his rapid readjustment if they understand his problems.

Another important factor in the returnee's morale is for him to feel that both his family and his community understand him and understand what he has gone through, and the effort he has made. This must be demonstrated in more than a perfunctory way. The returnee does not react favorably to the citizen who makes excessive inquiries about combat or boasts about a relative's war record or his own knowledge of bombing technic or offers to pay the checks at bars. The recognition he wants is on a different level. The returnees do not think of themselves as heroes. Their modesty is genuine. They have gone through an unpleasant job that they do not want to dwell upon, and at the present time, they are going through a transition period. They have a feeling of loyalty to those who did not survive. Many times they are not in the mood to talk about their experiences.

An understanding family or a friend can, in a quiet, reassuring way, make a returnee feel at ease, and feel welcome—and add to his self-confidence. Just now, there is a great wave of interest in the emotional problems of the returnee. Too often, an amateur psychiatrist in the family or community tries to draw out a veteran, and sees problems in him that may not exist.

If problems of adjustment actually do arise, either in the family or at work, requiring aid, it would be better to seek such aid from a trained person. For the amateur psychiatrist, it is better to offer sympathetic silence than energetic advice.

People have a tendency to become increasingly concerned about the attitudes of the men who are returning. With a huge army, a certain number will have operational fatigue and those with previously unstable personalities will have a difficult time adjusting, but this does not mean that all the people in service who return to civilian life will have some sort of emotional problem. The majority will not.

The need for widespread knowledge of mental hygiene is a problem of greater scope than the study of the reactions of the returning servicemen to war, which is but one facet of the question of more rational living and the avoidance of war.

The lag between the study of man's inner nature and the progress of the physical sciences has been so great that we have taken it for granted that this gap must always persist. It is time that we changed this attitude and actually looked to the scientific study of human conflicts to throw more light on sociology and education. Just as vast energy has been stored up in the atom, until now locked away and unavailable, so in man's nature, his own conflicts have withheld a great proportion of his energies from constructive use. If we could split away some of man's conflicts as scientists have done with the atom, great forces would be released for constructive purposes.

The American scene will not be static. The direction it will take will depend in part on how successfully the transition of the veteran in the social scene takes place. Mass education in the functioning of democracy and in the concept of individual maturity are essential. The concept of emotional maturity should be the core of our educational system, for it is the safeguard of democracy—government based on faith in the individual's ability to mature, to acquire knowledge and judgment.

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Parents of J . . . H . . .,* above, made every effort to discover why she seemed "slow" and could learn to speak only a few words in spite of help at home and in nursery schools. Then, when she was 4½ years old, examination by a skilled otologist revealed a serious hearing impairment. Under his direction, she was experimentally enrolled in public school, and a few months later received her first hearing aid. Helped also by special lip-reading instruction, she learned rapidly, scored an I.Q. rating close to the highest in her class, and upon entering the third grade her reading interpretation was equal to fifth grade standards. Her delight at her progress is shared by her parents and otologist, who continues his advice and help.

**Name omitted in accordance with medical principles.*

When a Sonotone Consultant makes an audiometric examination of hearing, the only medical advice he gives is, "Be sure to see your doctor." The audiometer accurately measures the extent of hearing loss across the tone range, and is invaluable in providing the closest fitting of a Sonotone to individual needs, for best possible hearing, if the doctor has advised use of a hearing aid.

OFTEN an otologist's care at an early age will prevent permanent hearing loss and the need for a hearing aid. Likewise, many investigators agree that once a hearing aid is found medically advisable, the greatest benefits will result from its immediate adoption.

Obviously a child of 3 or 4 years could not ordinarily be trusted to wear, constantly, a hearing aid representing a considerable investment. But even at this early age, part-time use of the aid within the home would help prevent interruption of normal learning progress.

The risk of delay lies primarily in the fact that a child who cannot hear properly is cut off from many of the experiences and lessons of others of his age, and may easily become shy and fearful of human contacts. Such children often appear dull—when poor hearing is their only defect.

There is also the risk that the *meaning of sounds* may be quickly forgotten. Even an adult has difficulty in distinguishing again among words and other sounds after a few months of not hearing. When a young child must wait too long for a hearing aid, progress and natural ease in its use is made much more difficult.

So many children have grown up with hearing losses unrecognized and unremedied that many States are now moving toward regular hearing examinations and clinical care in the public schools. Audiometric examinations, used by many school systems and individual otologists, measure accurately the extent of hearing loss. If you have any questions about your child's hearing, a doctor's examination, advice and care *now* may avoid an adult disability.

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BOOKS

Your Eyes

By Sidney A. Fox. Cloth. Price, $2.50. Pp. 191. New York: Alfred A. Knopf, 1944.

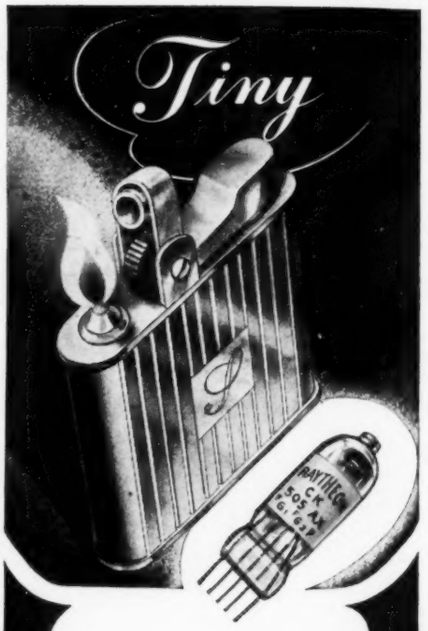
The available books for the public dealing with various phases of the human body are pleasurably increased by this new contribution. The author writes easily and with authority about the human eye. Every phase of vision is covered. Especially timely is the chapter on the eye in traffic. In one chapter the author puts squarely on the table for discussion the problem of the place to be occupied in the field of vision by the optometrist. Interesting also is the exposure of the so-called Bates system of seeing without glasses. The book can be recommended to any intelligent reader who wants to find out more about vision. M. F.

The New York Hospital—A History of the Psychiatric Service, 1771-1936

By William L. Russell. Cloth. Price, $7.50. Pp. 556. New York: Columbia University Press. April 1945.

Dr. William L. Russell, for twenty-five years closely identified with the New York Hospital, first as Medical Director of Bloomingdale and later as director of psychiatric work of the Society of the New York Hospital, has written a notable history of the first hospital to provide for the treatment of the mentally ill in New York State. More than a century and a half of psychiatric history is surveyed in this intimate account of the birth, growth and development of a great psychiatric service which has now attained mature stature in the present Bloomingdale Hospital and the Payne Whitney Psychiatric Clinic of the New York Hospital.

This work is of interest in that the development of clinical psychiatry in America was profoundly influenced by the pioneering work of the New York Hospital. The introduction in America of modern and, for the first time, humane methods of dealing with the mentally disturbed began with this hospital. At the very outset provision was made for admission of the mentally ill into a general hospital on the assumption that mental illness could be treated and was curable by medical means. This close association of psychiatric service with general medical services was soon interrupted. The later emphasis on recreational, social and educational methods of dealing with the mentally ill and the establishment of the psychiatric hospital at Bloomingdale in 1821 led to a long period of separation of the psychiatric service from other hospital services. Not until the opening of the Payne Whitney Clinic in 1932 was the cycle complete, with return of the psychiatric service to a setting in which there again could be close association with general medical services. GEORGE J. MOHR, M.D.



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Medical Research

(Continued from page 115)

tially serious infection which many American troops acquired through the skin when they waded in water on certain Pacific islands.

In the mammalogy and acarology laboratories, other scientists are studying mites, carriers of the deadly scrub typhus, under direction of one of the six leading experts on the subject in the United States. To properly analyze the disease it is necessary to follow the carrier-mite through its complete life chain. If the experiments are successful, it will mark the first time mites have been cultivated through the life cycle.

Another carrier of disease, the common fly, is the subject of intensive study in the entomology department. In the insectary here, four of the seven species of flies known to be on Guam are being raised under observation. Study of their habits is expected to bring about better control of flies as disease carriers. This is the first time certain species have been raised in "captivity."

Laboratories also are in operation in such fields as chemistry, bacteriology, viruses and malariology. A complete photographic laboratory and medical library also are included in the unit.

Bulk of the unit arrived on Guam Jan. 12, 1945. Proud as he is of the modern 62-building layout, Dr. Rivers is prouder still of the fact that the enlisted men of the unit built the plant themselves with the supervision of Seabees. All the buildings are Butler-type, prefabricated sheds, adapted to their scientific purpose by Dr. Rivers. One third of the laboratories are air-conditioned—but not for the comfort of the men who work there. Conditions must be kept constant, and the air free from dust, for controlled scientific work.

Besides the nucleus from Rockefeller Hospital, staff members were recruited from research institutions, hospitals and leading medical schools. Enlisted technicians were trained in the Naval Medical School, Bethesda, Md., and several were experienced in scientific work in civilian life.

Dr. Rivers is a graduate of Emory University, Atlanta, Ga., and the Medical School of Johns Hopkins University. He became interested in tropical medicine while working at the Santo Tomás Hospital in Panama in 1913-14, and first did research during the World War when assigned as a medical officer to a commission studying measles among American troops.

Following the war he taught bacteriology at Johns Hopkins before joining the staff of the Rockefeller Institute, where he became the leading American authority on filterable viruses and the youngest member of the Institute up to that time. He is

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Self-Portrait of a Lady

Artistically, how do you see yourself? Were you painting your own portrait you would use all your skill and artistry to reproduce the beauty of your coloring in your likeness; and if you flattered your likeness by softening some lines and highlighting others you would not be guilty of a very great vanity.

Every time you apply make-up you are in a sense creating a self-portrait. Whether or not that portrait is a masterpiece depends on the colors you use and the way you apply them.

As the artist selects a canvas of fine quality and suitable texture for his work, so in creating your cosmetic self-portrait your skin should be conditioned for make-up. Cleansing and lubricating creams and make-up bases serve this purpose.

The Cosmetic Consultants who distribute Luzier's Fine Cosmetics and Perfumes are artists in their ability to help you select basic preparations and make-up with which to make your self-portrait a masterpiece.

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a member of a number of scientific boards and is nationally known as an authority on infectious diseases.

Executive officer of the unit is Lt. Comdr. Francis F. Schwentker (MC), U.S.N.R., of Larchmont, N. Y., an expert in the field of public health who worked in Rumania for the Rockefeller Foundation and spent a year in France, after the German occupation, establishing public health units.

Some Nails Never See Red

(Continued from page 105)

A well known research pharmaceutic corporation is at the present time employing scientists who hope to solve the problem of combining ingredients that will form a nail base lacking the common allergens.

Knowledge of the irritating elements of nail polish seems quite remote in the minds of many eye doctors and skin specialists.

Heredity and environment, sources of many allergies, are not the causes in simple cosmetic irritations. Hypersensitivity is the cause. "Coloring matter, dye and lacquer are causes for rashes on the back of the neck as well as on the eyes.

"Just a few months ago there was an increase of women patients with rashes on the backs of their necks. The cause was the lacquer pads used to keep their back hair up, which was the current fashion."

Self-diagnosis can be conducted along the following lines. If one is so bothered by watery swellings on the skin, and contractions of involuntary muscle tissues, some form of allergy is apparent. Of course, people are affected differently and different degrees of affliction must be noted.

Allergic symptoms are produced by a combination of three factors:

1. The hereditary pattern.

2. Extent and duration of the exposure.

3. Properties of the allergen itself, or hypersensitivity.

The environmental factors are further illustrated by naming a few professions where allergent qualities are prevalent, such as: barbers, handling hair tonics, shampoos, sterilizing solutions; florists, plants and flowers; painters, paints and constituents; bakers, flour and chemicals.

It has also been noted that babies and blondes, who possess fair and delicate skin, are more prone to have skin allergies than other forms of allergies.

So, today we find that science, through its research for a non-allergic nail polish, has again come to the beautifying aid of the hypersensitive American woman whose pale-tipped hands will soon be able to vie with the rainbow tipped nails of her more fortunate sisters.

Personalities Remade

(Continued from page 123)

anchored in the new position. Tooth movements are not accomplished quickly—the usual time required is from one to three years.

If you ask an orthodontist the best age for corrective treatment he'll probably tell you that there is no such thing as a "best" age, and that it all depends on the individual case. When there is malformation of the jaws, he may recommend starting treatment at the age of three because of the greater degree of bone plasticity. As for crooked teeth, he'll want to have the child under observation from an early age so that preventive measures can be undertaken. In some cases he may recommend that straightening be postponed until the arrival of the permanent teeth.

But what about adults? Recently a popular radio announcer, in his late twenties, walked into an orthodontist's office. When he opened his mouth to talk, his crooked front teeth were conspicuous.

"Can't you do something with my teeth?" he asked. "When television breaks, I'm sunk."

"Not as much as I could have done for you ten years ago," the dentist told him, "but probably enough to get by."

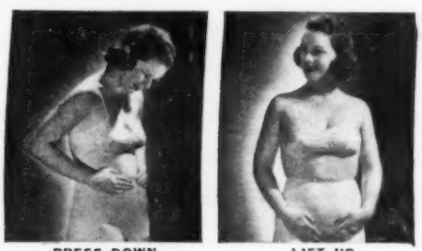
The teeth of adults can be successfully straightened in many cases, even after the age of thirty, but growth processes, necessary to hold teeth in the new position after they are moved, become slower with advancing years. A partial correction, which may be a very valuable improvement, is often advised for older patients as a substitute for the ideal correction possible in younger persons. Such a compromise remodeling was recommended and is being carried out for the radio announcer, so that his irregular teeth will not exclude him from a career in television.

Oral surgery may be called upon to remold severe deformities, as in the case of an accountant, whom his fellow workers called the "Ape man," because of his greatly elongated lower jaw, or "Grouch" because he usually was disagreeable and difficult to get along with. A surgeon removed a piece of bone from either side of his lower jaw, and then grafted the cut edges together (as with any fractured bone). When the parts had knit, an orthodontist took over and moved the teeth back into line. As soon as the work was completed, the man got another job with a firm where no one had known him previously. The feelings of inferiority which had been the cause of his bad temper vanished and his whole personality changed.

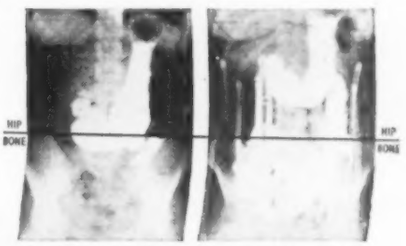
Dental science is accomplishing miracles in replacing natural teeth with artificial substitutes, but, here again, prevention is better than correction. Many extractions — some

I've got the biggest, loudest welcome mat in town!

1 I guess I've been "funny" about people who called at my house on business. But from now on I'm putting out a big WELCOME mat for *one* business woman anytime she wants to call! Why? Because this woman is in business for herself, just like any storekeeper except she doesn't have a store. She brings her service to your house instead. And she brought me more than service. She brought me a new feeling of being young and alive again—



2 You've probably guessed it, she's the Spirella Corsetiere. And the first thing she showed me was the famous Spirella Press and Lift Test. I pressed down on my stomach. Ouch! It felt like the ordinary corset. Then I lifted up. Right away I felt better and less tired.



Abnormally low position of stomach (Ptosis)

Same stomach properly raised with Spirella

3 "That's the way a Spirella makes you feel," she said. "And here are some new doctor-approved X-Ray pictures that prove Spirella supports you naturally inside as well as out, while other garments simply squeeze you in."

4 Then she adjusted the patented Spirella Modeling Garment on me to get accurate measurements for my new Spirella. And when she delivered my new Spirella it fitted perfectly. Now I feel and look years younger. Even my husband has noticed—and that's saying something! So you see now why I've got my welcome mat out for the Spirella Corsetiere. Invite her in when she calls at your house and you'll feel the way I do about this business woman who helps you to be young and alive again!

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dentists go as far to say *most* extractions — could be avoided if decay were arrested early enough. Pyorrhea, one of the chief causes of extractions in adults, can usually be prevented by good dental hygiene.

It is important that an extracted tooth be replaced, even though the gap may be far back in the mouth. If it is not, the teeth on either side will shift and trouble will begin. Modern restorations—fixed and movable bridges, full and partial dentures —are efficient, comfortable and good looking. The new acrylic (plastic) teeth are so realistic you can't tell them from real teeth.

If all of your upper or lower teeth must be extracted, it's no longer necessary, except in rare instances, to go toothless for a month or six weeks, waiting for the gums to heal. The new immediate denture technic makes it possible for you to have a denture that has been prepared for you prior to the extraction of your teeth. Jacket crowns make broken or discolored teeth unnecessary handicaps. As the name implies, a jacket crown is a thimblelike jacket or shell of baked porcelain or plastic, fitted over the trimmed-down crown of what is usually a living tooth. Because the nerve stays alive, this type of crown is superior to the old-fashioned crowns which necessitated removal of the nerve. As each crown is specially made for the tooth it is to cap, natural looking results are achieved.

"Miss Dripping Teeth" was the nickname given by her pupils to a 32 year old high school teacher. Her two lateral incisors (second teeth from the center) had never formed, although there was ample room for them, and the two central incisors had spread, leaving an open space between. The cuspids (eye teeth) were elongated and sharp, like fangs, and had drifted forward. When she opened her mouth, all you could see were these four widely separated teeth, which seemed to be dripping from the upper gum. Extremely sensitive about her deformity, she never smiled, keeping her mouth grimly shut. Finally, in desperation, she tearfully demanded of a dentist that he extract all her teeth and give her dentures. Since her teeth were sound, he refused to do this, but recommended corrective treatment. First, the incisors were moved together and the cuspids moved back into position. Then the cuspids were trimmed down and covered with porcelain jacket crowns, to each of which were attached porcelain dummy teeth to fill the place of the two missing teeth. These dummy teeth served the double purpose of filling the vacant spaces and holding in line the teeth which had moved. The whole operation took about a year and a half, but when it was completed the change in personality was miraculous. The young woman seemed to bloom overnight.

The pearly teeth of your favorite

movie glamour girl may be her own, but more often than not they are the dentist's contribution to feminine beauty. Perfect teeth are necessary for a screen actress. The intensity of the Kleig lights permits the camera to pick up and magnify even the tiniest flaws. Whenever a new "find" arrives in Hollywood, to be groomed for stardom, she is immediately referred to a dentist. Alinement is corrected, because small irregularities, photographed at certain angles, may cast shadows. Jacket crowns and bridges and partial dentures, and sometimes porcelain veneer appliances worn over the natural teeth during closeups, give the illusion of perfection.

These are some of the methods by which dental science corrects deformities. Personality changes follow corrective treatment so frequently that it's impossible to overemphasize the psychologic results. Modern dentistry is constantly developing new ways to help these unfortunate people build happier and more successful lives.

The Eyes Have It

(Continued from page 97)

fluid. The tissue screen behind the lens of Mary's eyes, like a ground glass barrier to clear sight, blocked the efforts of her eyes to focus. They wandered aimlessly in erratic, jerky movements, searching for what, she did not know. At first, protection against any sudden bright light made her cover her eyes. Soon rubbing them became a habit—grinding at them with her knuckles.

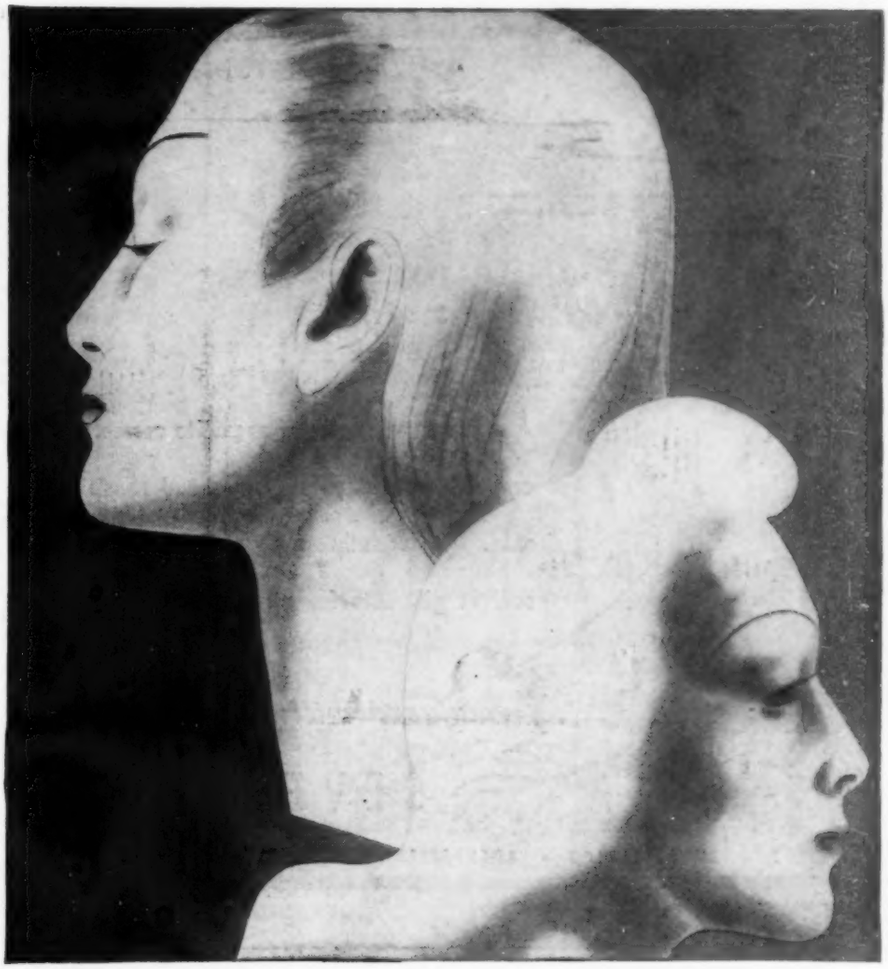
Between 2 and 4 months of age, coming events cast their shadows in blindness for one of eight premature babies. The relief and joy of nerve-wracked parents at their new love's survival turn abruptly to despair.

Now the distraught father and mother face the test of their character and devotion. Will they "abandon" their offspring to doctor and institution? Will they have the courage and assume the responsibility to rear their sightless darling in the affection that is every child's due and in the richness of life that training and instruction now offer to the blind?

The ophthalmologist, the medical social worker and the nursery school teacher aid the retrolental fibroplasia fight in sympathetic education of the preschool blind. But more than training for the child, they attempt to give the parents the key to the child's capacities. They suggest the way to mental growth through proper care.

Pity from neighbors, possibly masking scorn, is the cruelest form of torture for parents of the premature blind.

"And how is that poor blind baby of yours?" neighbor Jones asks Martha across the backyard. "What a shame she couldn't be like her sister!"



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Possibly cruel! Certainly tactless! Herb and Martha have reached that same conclusion independently. Its repetition makes Herb see red, piles debris into the flood of baseless guilt that courses through Martha's mind.

"What did I do wrong? Why must it happen to us? How are we going to pay the bills? I know it's something I did." Such mental mountains tower ominously to stifle the precious joy of parenthood.

Social agencies find common problems in the relation of parents to these preschool blind. These include anxiety over methods of training and education; fear over mental development; uncertainties on correction and prevention of "blindisms"; inability to plan realistically for the child's future in terms of blindness and finally, the question of institutional versus home care.

These problems are common, but their endurance is not. The parents feel so much alone and consider their blind babies virtual outcasts on the fringe of normal, happy children.

Only last June, an attempt to pool and possibly to solve the problems of blind children and parents on a group basis led to a two weeks summer school for 20 mothers and retrolental fibroplasia children. The Massachusetts Eye & Ear Infirmary and Perkins Institution for the Blind were the leading institutional lights in this figuratively "blind" venture.

This experiment produced definite and favorable results. The children, in working groups of three or four, learned concentration, acquired skill with clay and blocks. Their mothers heard experts explain retrolental fibroplasia and received first hand advice on nutrition, school technics, toys and games for the blind child, instruction in explaining the child's handicap to others, warnings against overindulgence and overprotection and a concrete knowledge of resources and training available to the sightless.

Psychologically, the mothers had the advantage of meeting others on a common ground. The weight of their solitude fell away under the exchange of experiences and ideas. They saw their sheltered, handicapped children playing contentedly with others, socially conscious, handled successfully by outsiders. The dread and uncertainties of blindness became less burdensome under the realization that help and training were available, and that other parents shared and could meet the challenge of a sightless child. The mothers learned to look at life objectively.

Without guidance, the blind child only sits and waits. He must be taught everything—to escape passivity, to play—perhaps to chew. He cannot learn by imitation for he knows not what others do. He is naturally an introvert, retiring, but with no stubborn backwardness of the feebleminded. He simply must be reached.

The blind child, too, is not un-

happy. Life for him is full, as far as he knows. Education and group activity can make him know more, carry him beyond such pitiful reflex actions as opening and closing doors, rolling his head from side to side.

Nor is the blind baby unresponsive in terms of what he knows. Mary Foster could not see her bottle. Mealtime to her meant the slam of a refrigerator door, the spurt of the warming gas flame. Twin Margaret must wait and see the bottle before she registered her preluncheon demands.

For blind children respond to sounds and to music in a greater degree than those whose eyes are clear. Their hearing is no more acute. They merely rely on it more, train it better. A blind child may identify a visitor by his voice six months after he has heard it for no more than two or three minutes. He has only ears, not eyes for the world.

Music hath charms to no one more than to the blind. Teachers find rhythm in the sightless, willingness to listen and retention of melody far greater than in groups of full vision children. To be sure, Alec Templetons and Jimmy Osborns are rare, but blind youngsters find music soothing, relieving their sensitive tension. They sing well, have a good sense of pitch. The notes draw them out of themselves, offer a sense of security in familiar strains both of classical music and clapping songs.

Suppose we visit blind babies in their nursery school group. Swarming youngsters trot over the grass, squirm in and out of toy automobiles or swing blithely from trapeze and parallel bar with never a bump or misjudgment of distance. Just any kindergarten at play, we imagine, observing from the street. But inside the yard, masked by the babble and chatter, the tiny steps have a brief hesitancy, the hands grope for the outline of a familiar toy or landmark.

A strange voice is quickly the target for childish curiosity. This centers on identity and what we are carrying.

The first query by all—"What's your name?"

"Bill."

From then on it's Bill by the sound of his voice, and they all remember. Let Lucy Jane be the spokesman for the crowd.

"What's that?"

"That's my hat."

"Why does it have that cloth?"

"That's the band that holds it on my head."

"Why don't you put it on your head?—You want to see my new shoes? They're brown."

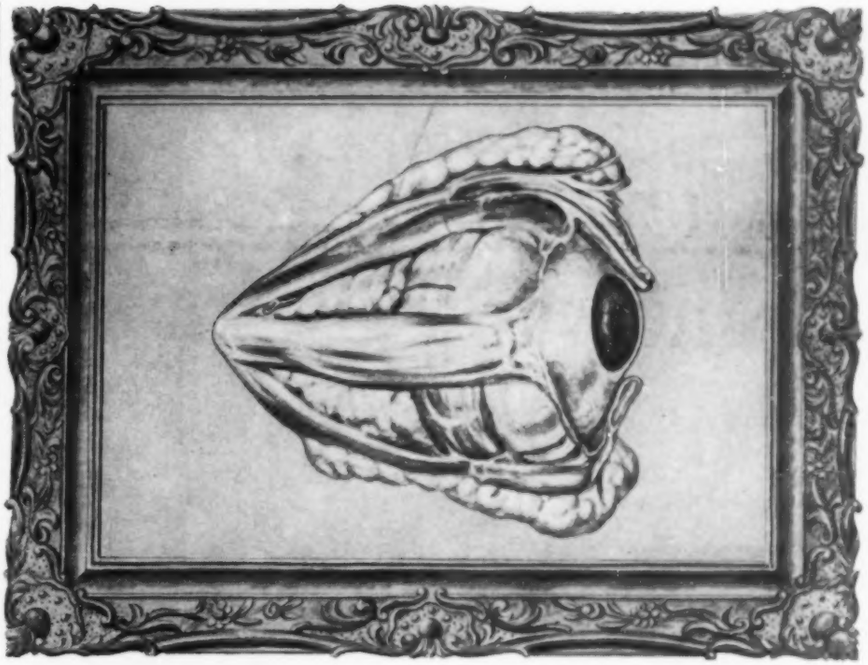
We admire the new shoes. Then Lucy Jane is called to wash her hands.

"Are your hands clean, Bill?"

"Yes, I think so."

"Let me smell them. Well, they're getting kind of dirty. You'd better wash them."

And so it goes. Childish joy pushes



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aside life's dark curtain to find contentment under proper guidance and training. Each child recognizes and tolerates as a matter of course the varying handicaps of others. Those with partial sight instinctively look out for the totally blind, nudging them aside from occasional ventures into danger.

"Come Lucy Jane, it's time to go in for supper."

"No, I want to wait and see Bill go."

Lucy Jane can only "see" him go in hearing his voice when he says goodbye, a voice a note huskier than usual. Bill won't forget her and the others. By his voice, most of them will remember him next time.

Retrolental fibroplasia to date has no cure, merely remedies. This progress by social group is one. Devoted, intelligent care at home is another. Difficult and sometimes inconclusive surgery is a third. But back of cure or prevention lies determination of the cause. This, too, is in doubt.

The causes fall into two classes. The first is related to the parents, before the child is born. They include such factors as heredity, illness during pregnancy, blood incompatibility, use of new medication and processes that produce prematurity.

Heredity seems definitely ruled out—the presence of the disease in only one twin indicates this. None of the others, either through consistent presence or absence in retrolental fibroplasia, give the answer to the malady.

The second group pertains to the premature child himself. His own incomplete engine must supply the power normally secreted by the mother's thyroid, pituitary, adrenal glands and ovaries.

Oxygen in the incubator means the lungs are not ready. Underdeveloped digestive systems cannot utilize fats and fat soluble vitamins such as Vitamin A. The premature change from the darkness of the uterus to a colder, brighter world of air and light sets up another strain. Any, or all or part of these may develop abnormalities in the eyes.

The laboratory has a role in trying to detect and sort these causes. It can attempt to reproduce the disease in the young of animals by taking possible causes or combination of causes into the test tube.

Babies, obviously, are too precious for experiments on retrolental fibroplasia. Monkeys are closest in the physical scale, but obtaining the premature young from the mother and raising them successfully is a formidable hurdle.

Rabbits and rats for tests of Vitamin A deficiency make up the joint laboratory study of the cause by the pathology departments of Massachusetts Eye & Ear Infirmary and the Harvard Medical School. They are cooperating in sharing equipment, technic and research. In this, the more specialized the problem, the more selfless is medicine in rallying to the attack.

From the nature of the disease, this laboratory scrutiny still ranks in the experimental stage. Major doubts rest in the successful transfer of animal findings in application to humans, in uncertainty over early nutrition of animal eyes, in the requirements of materials to make up deficiencies.

It is possible that the disease may go along with the animals in prematurity as in humans. Or, its reproduction may be successful by proper combination of causes in a full term rabbit or rat. After five years of laboratory study, the test tube yields only the same result as the disease itself—ignorance of the cause and the cure. The multitude of Vitamin A deficiency tests at different ages and on diverse diets would normally exact high toll from experimental animals. But a blood testing spectrophotometer acts as a merciful and economical angel in sparing the laboratory treasures. Its blood analyses require two drops or less of blood, easy, indeed, on the animals, but priceless in determining the vitamin A levels in the babies themselves.

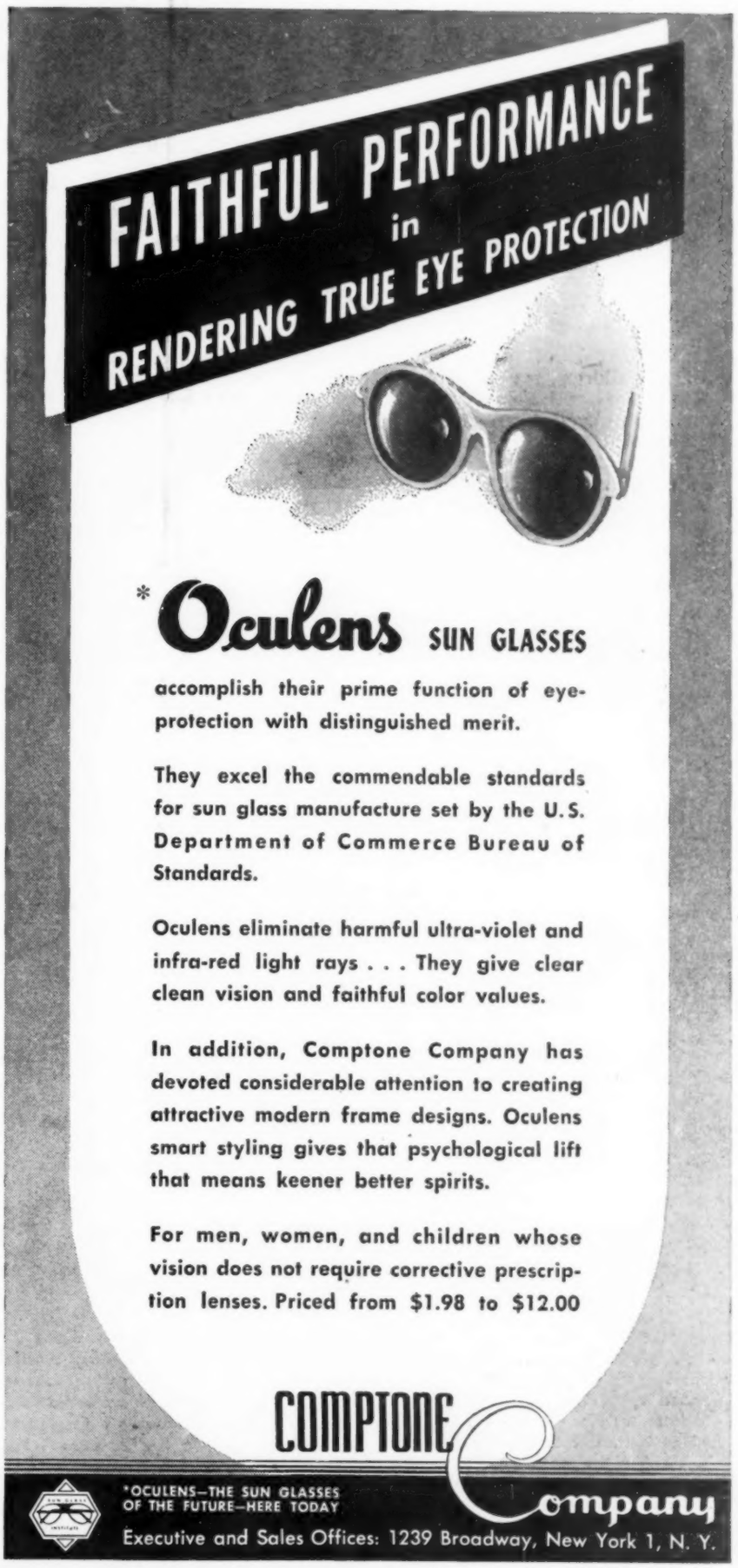
Formidable, in sum, are the problems that retrolental fibroplasia poses to the home, the physician, the medical social worker and the laboratory. Its miseries can only be alleviated, not cured. At least its presence as a postnatal disease is now recognized. It need no longer be confused with tumor which means removal of the eye, or congenital cataracts.

Complications may arise with the disease itself. These include glaucoma, adhesion of the iris to the lens, opacity of lens and cornea, and hemorrhages, all, along with the malady's fibrous curtain, contributing to the reduction of vision.

The natural question by this time has arisen. What can be done? True, there is no cure, but for a cure there is the gleam of hope. Treatment now can prevent complications, conquer serious secondary developments that spell destruction for the eyes. This medical and surgical treatment that can vary widely with each eye involved reduces the ravages of the disease. Later, if today's faithful studies produce a cure, the remedy will have a relatively sound eye on which to work. Though slender and weak, the hope is defiantly alive.

Simple humanity, aid to the young and helpless, spurs the surgical and allied legions in the retrolental fibroplasia fight. They accept the challenge of this evil's ascendancy when older diseases are meeting their medical match. Today, the nation's blind number close to 200,000. Any unchecked scourge that now produces more than 400 new cases of blindness a year can soon be the affliction's most common cause.

Time, in support of medicine, is admittedly the great healer. And, for this childhood sickness of the eye, time is on the side of money, brains, equipment, and love in working far and beyond a cure to find the ounce of prevention.



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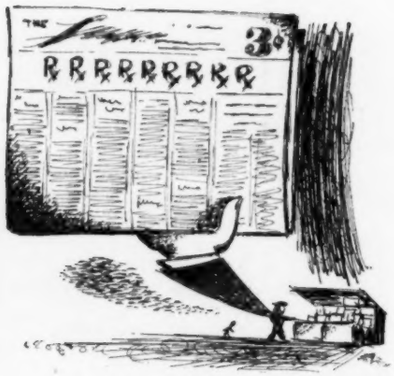

HANDWRITING of aggressive, noisy children is characterized by heavy lines and angular forms, while shy, timid youngsters are likely to write faintly, forming small letters without flourishes, Dr. Selna Schryver stated in an article in the *Journal of Nervous and Mental Diseases*. Because the study of children's handwriting is handicapped by their inability to spell, and similar complications, Dr. Schryver devised a handwriting test in which children are asked to make simple, basic letter forms 20 times apiece. With this sample, information about the child's personality makeup, including intelligence level, character traits and emotional maturity, can be obtained.

* * *

ATOMIC bomb discussions and the belief that for every weapon of offense a newer method of defense can be developed, lends interest to a recent editorial in the *Journal of the American Medical Association*. The editorial discussed the police "lie detector," and what J. E. Reid, writing in the *Journal of Criminal Law and Criminology*, had to say about it. According to Mr. Reid, a number of criminals, using true military tactics, have figured out a way to "beat" the machine. They squirm around, moving certain muscles—so quietly that they cannot be observed—thus making the blood pressure readings so ambiguous that the examiner cannot make a definite diagnosis. Mr. Reid knows this can be done because he's tried it himself. But, lawbreakers are going to have to perfect a new defense technic, because Mr. Reid has devised an instrument to separate true from false lies—which the police may find valuable. Using Mr. Reid's method, inflated rubber bladders are placed under the forearms and thighs of the suspects. The bladders are connected with three separate units which record and designate muscular exertion of the subject's feet, legs, arms and hands. Surreptitious wriggling can consequently be detected and the resulting hieroglyphs on the recorder discounted. We often wonder why criminals don't give up crime and turn to an easier way of making a living. A sawed-off shotgun hasn't a chance against science.

* * *

THE laboratory in Würzburg, Bavaria, where Konrad Roentgen discovered x-rays, remains undamaged today in spite of the heavy bombing and street fighting to which the city submitted. The Physical Institute of the university, housing the laboratory and Roentgen historical collection, escaped with minor damage—shattered windows, broken slate and loosened plaster, according to Major Lewis E. Etter, of the Army Medical Corps.

Major Etter visited the institute and laboratory recently and relayed this information to physicians in the United States. He said that during the push of last April, when our armies slashed through Würzburg to Nuremberg, our bombers and big guns, either by accident or design, spared the historical medical landmark.

* * *

IT'S possible that we hear too much about accident statistics, and that familiarity with their staggering totals breeds contempt for their significance. But some figures recently published by the National Safety Council deserve study, as an object lesson in horror. Comparing war and accident casualties, in the period between Pearl Harbor and V-J Day, the Safety Council announced that our war casualties, including men killed, wounded, missing and taken prisoner, totalled 1,070,524, while the home front accident toll reached 36,355,000 persons killed and injured. The army and navy report 261,608 men killed, but 355,000 civilians died because of accidents during the same period. Among the 36,000,000 civilians injured in their routine, everyday existence, 1,250,000 will bear some permanent disability. Of course, compared by percentages, these figures wouldn't look as black. But, however you look at them, the result is awe-inspiring.

* * *

ALTHOUGH many organizations are working to keep children occupied and busy during their leisure hours, little has been done to provide entertainment for another group that has too much free time—old people. Recently, in New York City, the Yorkville Civic Council launched a recreational program for the aged, and the success of their efforts may spur other civic groups to interest elderly men and women in the community's life. In many cases old people have nothing to do but sit in furnished rooms and "spin out their years in loneliness, feeding on nostalgia instead of hope, on memories instead of activity." These words were provided by F. R. Alderstein, who discussed the Yorkville program in a recent issue of *Recreation*. At two settlement house teas the old people were entertained with movies, home musical talent, group singing and refreshments. The program has now been expanded to include lectures, classes and various social events, held in the settlement houses, and planned for old people exclusively.

Many of the old ladies sew—for themselves, the Red Cross and local hospitals—some have earned extra money with their needles. Best of all, old people meet companions of their own age. As one old gentleman said, "I had no idea there were so many of us old folks in Yorkville. It kinda makes me feel better." Illustrating poignantly the loneliness in which many of these forgotten older people live is an anecdote attributed to Helen Hardy Brunot, and quoted by Mr. Alderstein. A librarian referred a 70 year old man to a social agency because she noticed he needed glasses. During his conversation with the case worker, the man told her that although he couldn't see to read he went to the library because it was a place "to be with people."

* * *

UNDER the sponsorship of the Rockefeller Foundation, ten Korean physicians recently came to the United States to study advanced health and medical subjects. (For the past 30 years the Japanese have dominated Korea's medical and other scientific work, making it impossible for a Korean to hold a position of responsibility in these fields.) Surgeon-General Norman T. Kirk, of the U. S. Army, hopes "that these men will form the nucleus of a new medical service for their country, and if earnestness and enthusiasm are true criteria, they will succeed." The doctors, in groups of three and four, will spend a year studying, at Johns Hopkins, Harvard and the University of Michigan medical school. They will then return to Korea, where they will establish the foundation for a self-sufficient and independent medical service.

—KATHLEEN SIMMONS